

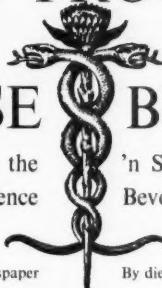
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MEDICAL PROCEEDINGS

MEDIESE BYDRAES

A South African Journal for the
Advancement of Medical Science

'n Suid-Afrikaanse Tydskrif vir die
Bevordering van die Geneeskunde



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7 Februarie 1959 February 7

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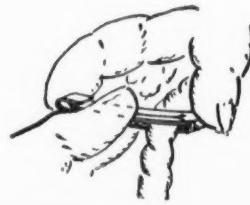


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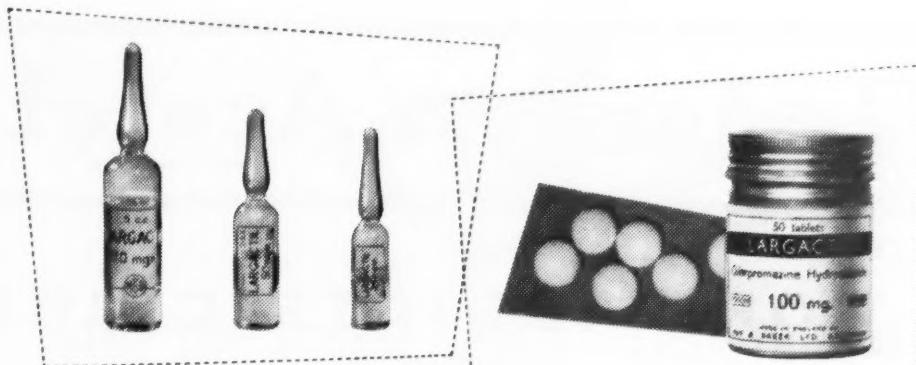
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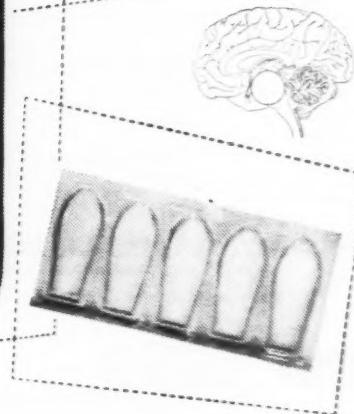
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Medical Proceedings · Mediese Bydraes

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REFERENCES: 1) Smith, R. T.: To be published. 2) Holley, H. L.: Personal communication.

3) Passarelli, E. W.: Personal communication. 4) Peak, W. P., and Smith, R. T.: To be published. 5) Settel, E.: Personal communication. 6) Wiesel, L. L.: Personal communication.

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No. 3

REDAKSIONEEL · EDITORIAL

'N PNEUMOKONIOSE-KONFERENSIE IN JOHANNESBURG

A PNEUMOCONIOSIS CONFERENCE IN JOHANNESBURG

Vooraanstaande wetenskaplikes is deur die Raad vir Wetenskaplike en Nywerheidsnavorsing namens die Regering uitgenooi om 'n internasionale vergadering oor pneumokoniose vanaf 9 tot 21 Februarie 1959 in Johannesburg by te woon.

Mediese, ingenieurs-, chemiese, natuurkundige en radiologiese deskundiges sal dus 'n geleentheid kry om mekaar te ontmoet om alle aspekte van die pneumokoniose-probleem te bespreek. Elders in hierdie uitgawe publiseer ons die program wat vir die konferensie opgestel is. Dit gee 'n aanduiding van die baie omvattende aard van die besprekings wat aanstaande week begin.

Die President van die konferensie is prof. S. F. Oosthuizen en die Sekretaris-generaal is dr. A. J. Orenstein (die eerste Direkteur van die Raad vir Wetenskaplike en Nywerheidsnavorsing se Pneumokoniosenavorsingseenheid in Johannesburg).

Met die oog op die vooraanstaande rol wat die Unie lank reeds speel in die bestryding van die probleme wat gedurende die volgende veertien dae bespreek sal word, kon geen gesikter plek as Suid-Afrika vir hierdie belangrike vergadering gekies gewees het nie. Wat betref die opsporing en behandeling van pneumokoniose, en die vergoeding van die slagoffers van hierdie siekte, neem Suid-Afrika waarskynlik die voorste plek in onder al die lande van die wêreld. Op die onlangse Internasionale Kongres insake Fotofluorografie is die des-

Eminent scientists have been invited by the Council for Scientific and Industrial Research, acting on behalf of the Government, to attend an international meeting on pneumoconiosis in Johannesburg, from 9 to 21 February 1959.

Medical, engineering, chemical, physical and radiological experts have been given an opportunity to meet in order to discuss all aspects of the pneumoconiosis problem. We publish elsewhere in this issue the programme of the sessions. This indicates the very comprehensive nature of the discussions which begin next week.

The President of the Conference is Prof. S. F. Oosthuizen and the Secretary-General is Dr. A. J. Orenstein (the first Director of the CSIR Pneumoconiosis Research Unit in Johannesburg).

No more appropriate venue than South Africa could have been chosen for this important meeting in view of the lead which this country has taken in dealing with the problems to be discussed within the next fortnight. South Africa is probably foremost in the world in the services it provides for detecting, treating and compensating sufferers from pneumoconiosis. At the recent International Congress of Photofluorography, the informed view was expressed that the Union was at least 5 years ahead of the rest of the world in the technical services provided for dealing with pneumoconiosis and related problems.

kundige mening trouens uitgespreek dat die Unie die res van die wêreld ten minste 5 jaar vooruit is wat betref die dienste wat vir pneumokoniose en verwante probleme beskikbaar gestel word.

Een van die belangrikste funksies van die Johannesburgse vergadering is om navorsingswerkers 'n geleentheid te gee om gedagtes te wissel, en om die ondervinding wat hulle opgedoen het met die werk wat reeds aangepak is, aan ander afgevaardigdes te verduidelik. Met vertroue wil ons ons dan ook aan die voorspelling waag dat talle nuwe navorsingsweë oopgestel sal word as regstreekse gevolg van die belangrike besprekings wat eersdaags in Johannesburg plaasvind.

Rasseverskille, veral soos hulle in Suid-Afrika voorkom, kan bes moontlik 'n ingrypende invloed op die radiologiese diagnose van pneumokoniose uitoefen. In hierdie tydskrif¹ het prof. Oosthuizen onlangs 'n fundamentele bydrae gelewer oor die belangrikheid daarvan om, by die diagnose van siektes, rekening te hou met moontlike antropologiese afwykinge tussen verskillende etniese groepe. Die X-sdraalillustrasies wat sy referaat vergesel het, behoort 'n waardevolle grondslag vir die evaluasie van longkwale by die natuur te vorm, en verskaf tegelykertyd 'n nuttige leidraad wat bes moontlik verder ondersoek kan word in ander dele van die wêreld waar dieselfde probleme aangetref word.

Die vergadering sal ongetwyfeld talte voorbeeldelike verskaf van die wedersydse waarde van 'n uitwisseling van inligting. Trouens, die sou baie nuttig wees, indien, as gevolg van hierdie belangrike vergadering, ondersoek ingestel kon word na die moontlike uitruiling van navorsingswerkers tussen verskillende lande met gemeenskaplike probleme.

Ons in Suid-Afrika het veel wat ons die buite-landse navorsingswerkers kan bied, maar tegelykertyd kan ons ook aansienlik baat by hierdie tweerigtinggedagteswisselinge. Sonder die minste twyfel sal hierdie soort internasionale samewerking groter en vinniger resultate oplewer as internasionale kongresse, hoe waardevol laasgenoemde ook al is.

Ons verwelkom ons buitenelandse besoekers baie hartlik, en vertrou dat die deelnemers aan hierdie belangrike vergadering op 'n waardevolle en leer- same wyse gedagtes met mekaar sal kan wissel.

One of the important functions of the Johannesburg meeting will be to give research workers an opportunity to exchange views and experiences on work actually in progress. It can confidently be predicted that many new avenues of investigation will be opened up as a result of the important discussions about to take place.

Racial differences, particularly as they exist in South Africa, may profoundly influence the radiological diagnosis of pneumoconiosis. Professor Oosthuizen has recently made a fundamental contribution to these pages¹ dealing with the importance of taking into account possible anthropological differences between various ethnic groups in assessing disease. The X-ray illustrations which accompany his paper should provide a valuable basis for the evaluation of lung disease in the African and constitute a useful clue which could be followed up in other parts of the world where the same problems may exist.

Undoubtedly many examples will emerge from the meeting which will illustrate the reciprocal value of an exchange of information. Indeed, it would be useful if, as a result of this important gathering, the suggestion was followed up to establish an exchange of research personnel between different countries with common problems.

We in South Africa have much to offer to research visitors and also much to gain by this two-way travel in the traffic of the mind. There can be little doubt that this type of international collaboration will achieve greater and more rapid results than international congresses, however valuable these may be.

We extend a hearty welcome to our overseas visitors and trust that all the participants in this important meeting will enjoy a profitable and instructive exchange of views.

GENEESKUNDE

Op die mediese toneel verwelkom ons van-deeweek 'n nuwe mediese maandblad wat geheel en al in Afrikaans gepubliseer word en die passende naam *Geneeskunde* dra. Die verskynning van hierdie blad kan dan ook teregt as 'n geskiedkundige stap in die ontwikkeling

We welcome to the medical scene this week a new monthly medical journal published entirely in Afrikaans with the appropriate title *Geneeskunde*. This marks a historic step in the evolution of Afrikaans as a technical language.

1. Oosthuizen, S. F. (1958): *Certain Differences in the Radiological Appearance Between the Lung Fields of the African and the European: A Preliminary Report*, Med. Bydrae, 4, 635.

1. Oosthuizen, S. F. (1958): *Certain Differences in the Radiological Appearance Between the Lung Fields of the African and the European: A Preliminary Report*, Med. Proc., 4, 635.



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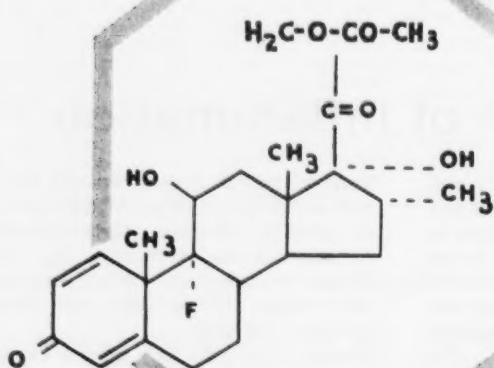
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REFERENCE: Bunim, Joseph J., Black, Roger L., Lutwak, Leo, Peterson, Ralph E., and Whedon, G. Donald, Arthritis and Rheumatism, 1:313-31, Aug., 1958.

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van Afrikaans as 'n tegniese taal beskou word.

Die stigting van twee mediese skole met Afrikaans as die medium van onderrig het die komste van 'n blad soos *Geneeskunde* net 'n kwessie van tyd gemaak.

Alle tale verkeer gedurig in 'n toestand van onvastheid, en die taak van die jongere tale om hulle by die uitgebreide behoeftes van die moderne geneeskunde aan te pas, was dus inderdaad veeleisend.

Afrikaans staan van aangesig tot aangesig met al die probleme wat deur 'n jong en groeiende taal die hoof gebied moet word, en hierdie probleme het 'n des te groter omvang aangeneem omdat Afrikaans hom binne so 'n kort tydjie by die moderne mediese literatuur moes aanpas. Wat dit betref, het die twee mediese skole reeds 'n aansienlike bydrae gelewer, maar sonder die minste twyfel sal die publikasie van 'n uniale maandblad ewe groot stukrag aan die vorming en stabilisasie van die taal gee.

Geneeskunde sal ongetwyfeld ook 'n ander baie nuttige funksie vervul. Dit sal Engels-sprekende mediese praktisyens naamlik 'n geleentheid bied om vertroud te raak met die Afrikaanse mediese terminologie. Dit is 'n belangrike praktiese oogmerk met die oog op die steeds groter gebruik wat van Afrikaans gemaak word by die aantekening van die siektevoorgeschiedenis van pasiënte, selfs in die hospitaal wat aan die Engelssprekende mediese skole verbonde is.

Sonder enige twyfel hoegenaamd sal *Geneeskunde* 'n kragtige aansporing vir skepende mediese literatuur in Afrikaans wees. Geeneen van die bestaande tweetalige tydskrifte het eintlik veel op hierdie besondere gebied gepresteer nie.

In 'n sekere sin is dit passend dat die senior van die twee Afrikaanssprekende mediese skole die voorhou geneem het met die totstandbrenging van *Geneeskunde*. Die publikasie daarvan in 1959, wat 'n feesjaar vir Afrikaans is, is 'n gelukkige sameloop van onstandighede, want vandejaar word die vyftigste jaardag van die Suid-Afrikaanse Akademie gevier, en ons herdenk ook 'n belangrike datum in die wordingsgeschiedenis van die Afrikaanse letterkundige beweging.

Die verklaarde beleid van *Geneeskunde* is om politieke en medies-politieke vraagstukke te vermy. Dit sal die steun van die hele mediese professie verseker vir die verdere vervolmaking van Afrikaans as taal.

Ons wens ons tydgenoot geluk met sy verskynings, en wens hom alle welslae toe met die bereiking van sy pryswaardige kultuuroogmerke.

With the establishment of two medical schools in which instruction is given in Afrikaans, the emergence of *Geneeskunde* was only a matter of time.

All languages are constantly in a state of flux and the task of the younger ones in adapting themselves to the extensive requirements of modern medicine is indeed demanding.

Afrikaans has to face all the problems of a young and growing language, problems all the greater because it has had to adapt itself within such a short time to modern medical writing. The two medical schools have already made a considerable contribution in this respect, but there can be little doubt that the existence of a national journal will make an equally great contribution to the moulding and the stabilization of the language.

Geneeskunde will undoubtedly also be put to the extremely useful function of giving English-speaking medical practitioners an opportunity of familiarizing themselves with Afrikaans medical terminology. This is an important practical objective, in view of the increasing demands made on the use of Afrikaans in taking patients' histories, even in the hospitals attached to the English-speaking medical schools.

There can equally be little doubt that *Geneeskunde* will act as a powerful stimulus to creative Afrikaans medical writing. None of the existing bilingual journals has ever succeeded adequately in this regard.

In a sense, it is fitting that the senior of the two Afrikaans-speaking medical schools should have taken the main burden of creating *Geneeskunde*. Its publication this year, a festive year for Afrikaans, marks the time propitiously, since 1959 is the fiftieth anniversary of the *Suid-Afrikaanse Akademie* and also commemorates an important anniversary of the inception of the Afrikaans literary movement.

The declared policy of *Geneeskunde* is to avoid political and medico-political entanglements. This will encourage support throughout the whole profession for the further fulfilment of Afrikaans as a language.

We congratulate our contemporary on its emergence and wish it every success in the achievement of its laudable cultural aims.

THREE BREAST CONDITIONS WHICH REQUIRE CLARIFICATION

1. MONDOR'S DISEASE

A. LEE McGREGOR, M.Ch. (Edin.), F.R.C.S. (Eng.)*

Jobannesburg

There are 3 affections of the breast which are ill understood and which may cause confusion in diagnosis and erroneous treatment. These are:

1. Mondor's disease.
2. Duct fistula.
3. Discharges from the nipple.

All the conditions mentioned are of a minor nature and will fall in the first instance within the province of the family practitioner. Mondor's disease and duct fistula are seldom seen and merit description. Discharges from the nipple are common but experience has amply shown that their significance is frequently misunderstood and that treatment is often misdirected and sometimes quite unnecessarily mutilating.

1. MONDOR'S DISEASE

This condition presents as a subcutaneous cord-like structure just under the skin of the breast in young and middle-aged women.

On reviewing the records of breast cases seen in private practice the writer has found 4 cases which fall into this group. The histories are as follows:

Case 1. This patient was referred by Dr. D. Durbach of Johannesburg in November 1948. Mrs. R. M. S., a records clerk, age 41, was married with twin daughters, age 17 years.

A week before she had noted a vertical cord on the under surface of the right breast which was tender then but not at the time of examination. Her general health was indifferent. She had undergone an operation on the uterus 4 years before because of pain in the lower abdomen at the time of her periods.

On examination there was found a curious subdermal tight cord on the under surface of the right breast (Fig. 1A). The cord branched. It was neither tender nor red. On elevation of the breast, the cord was seen to cross the inframammary sulcus on to the chest wall like a bow-string.

The condition was thought to be a subsiding phlebitis of a subcutaneous vein. No treatment was advised. The cord disappeared in 2 months.

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Case 2. Mrs. K., a doctor's wife, age 31, had 2 children. She had been under observation since 1943 because of nodular fibro-adenosis in both breasts. Her general health was good.

In July 1950 she came for periodic examination. Under the skin of the right breast was what felt like a piece of string (Fig. 1B). It had existed for a week. The slight initial tenderness was gone. There was no discolouration. No treatment was advised. The cord disappeared in a few weeks.

Case 3. This patient was referred by Dr. Beyer of Hanover. She was first seen in February 1953. Mrs. S. E. M. P. was a housewife, aged 55, married. Fourteen days before she had felt pain beneath her left breast and noted a string there. There had been no discolouration. She had had no previous breast trouble. She had 4 children and had passed the menopause 4 years before. The past history was not relevant.

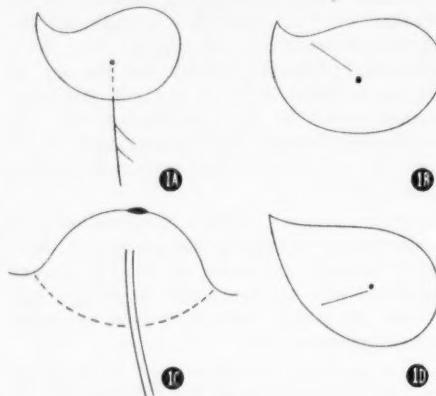


Fig. 1. Diagrams of the cord-like structures in the 4 cases.

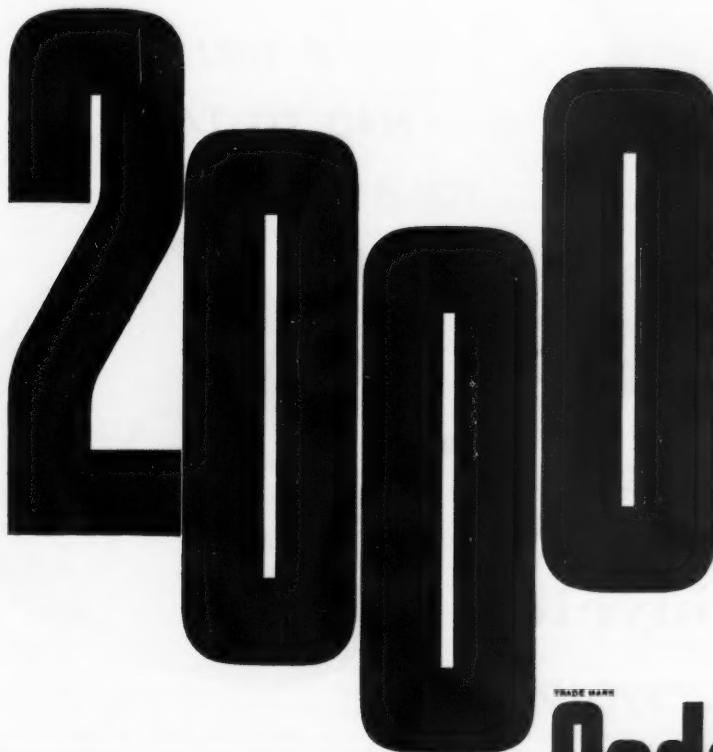
In case 1 (Fig. 1A), the dotted line indicates the cord on the under surface of the breast.

In case 3 (Fig. 1C), the breast is turned up to show the cords on its inferior surface.

On examination the only abnormality found was a double tense cord (Fig. 1C) extending from the under surface of the left breast to the adjacent chest wall. When the breast was elevated the cords stood out tensely. Both the cords and the breast were a trifle tender.

The condition was diagnosed as a subsiding phlebitis of a subcutaneous vein. No treatment was advised and the cords disappeared in 3 months.

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Case 4. Mrs. L. L., a doctor's wife, age 33, housewife with one child age 2 years, said that a week before both breasts became painful but that the pain was subsiding. Her general health and functions were normal.

On examination there was a generalized nodular fibro-adenosis of the breasts.

On the outer aspect of the right breast was a curious subcutaneous cord like a string of catgut (Fig. 1D). It was 3 inches long. No other abnormality was found. No treatment was advised. The cord disappeared in the course of a year, but occasional breast pain occurred for a further year.

When the first of these cases was seen in 1948 the writer was unaware of the nature of the condition, and considered the cause of the string-like appearance just under the skin to be the remnant of a subsiding phlebitis in a superficial vein. All the cases were related to the breast, all were married. Three of the 4 cases were between the ages of 30 and 40 and the other was 55, the menopause having occurred 4 years before.

All the patients had noted slight breast pain one or two weeks before being sent to the writer and at this time there was no pain or tenderness, except in Case 4. In 2 cases there was associated generalized nodular fibro-adenosis which had no apparent relation to the subsiding phlebitis. All the women had had children. The youngest child in the group was 2 years old when the mother was first seen so that lactation was not a factor in the development of the phlebitis.

In no case was surgery or other treatment advised and in all the cases the cord disappeared in a few weeks or months.

Mondor's disease was first described by French writers. In 1922 Fiessinger and Mathieu¹ gave an account of the condition. Favre² (1922) described a superficial phlebitis of the veins of the chest wall. It was, however, Mondor's communication³ in 1939 which first aroused interest in the subcutaneous cord-like structures in the breast with which his name is associated. He described the lesion as an angeitis. Little more was heard of the condition until reports began to appear in the American literature. In 1955 Farrow⁴ (from New York) reported a series of 43 cases. Kaufman⁵ (1956), in an excellent historical and clinical review of the subject, suggests that the eponymically designated disease be called subcutaneous phlebitis of the breast or chest wall. The phlebitic explanation of the condition is not, however, generally accepted. Jönsson, Linell, and Sandblom⁶ (1955) from the University of Lund studied 8 cases histologically and concluded that the condition was a lymphangitis with a pronounced tendency to sclerosis. It is of inter-

est that Mondor,³ after study of the histology of his first case, also considered the condition to be of lymphatic origin. Later⁷ (1944) he concluded that phlebitis was the more likely explanation. Hughes⁸ (1952) studied 5 cases, using the term sclerosing peri-angeitis of the lateral thoracic wall. He stressed the fact that the condition was inflammatory, the etiology being unknown. He emphasized the point that there was gross sclerosis around some vessel or vessels. He reviewed the histological features of 9 cases as follows:

1. One or more lumina were present.
2. Thickening of the intima was at times almost complete but some indication of the lumen could usually be found.
3. There was gross thickening of the adventitia.
4. Predominantly there was a connective tissue proliferation with some smooth muscle tissue.
5. Wandering cells, both of small round and polymorphonuclear leucocyte type, were present.

He suggested the condition be called sclerosing peri-angeitis of the lateral thoracic wall.

As there is thus no agreement on the best name for the condition, perhaps it would be advisable to adhere to the eponym.

COMMENTS

Mondor's disease is a rare condition. Although Farrow⁴ reported 43 cases from the Memorial Hospital of New York, they represented a collection over an 8-year period from a great hospital in a huge population area. The doctor working in the country or less populous regions will rarely, if ever, encounter the condition.

Typically, the condition occurs immediately under the skin of the breast and often extends across the inframammary sulcus to the chest wall, so that elevation of the breast brings the cord out in high relief. It may branch, be double or even beaded and, on occasions, may produce a grooved appearance of the skin. The cases described here were all related to the breast and in 2 cases the cord or cords extended down to the adjacent chest wall.

The superficial venous and lymph drainage of the breast radiates like a cart wheel, so that a thrombophlebitis of a vein over the mamma could extend in any direction to the larger receiving vessels. Thus extension over the border of the great pectoral towards the axilla has been described, but much the commonest extension wide of the breast is in a caudad direction on to the front of the chest wall crossing the inframammary groove. The cord feels like a strand of No. 4 catgut and has the firm consistence of a ureteral catheter.

In 3 of the 4 cases here reported it was painless when seen and felt. It occurs in both sexes. Young and middle aged females are most commonly affected. The ages here were 55, 33, 41, 31, and all were parous. One case was reported by Pascalides and Funck-Brentano (1951) in a boy of 8 years.

Symptomatically the condition appears as a mildly tender strand somewhere in relation to the breast. The tenderness soon subsides and a non-tender, firm cord remains. It may vary in length from 2 to 25 cm. and may be branched or double. In this small group of cases the cord disappeared over a period of a few weeks or months.

The etiology is quite unknown. Although injury or infection or biopsies have all been indicted, the fact remains that in most cases there is no such causative factor.

The condition causes trepidation in the patient and interest in the doctor because of its possible relationship to cancer. There is no such association. Mondor's disease presents as such a localized simple condition that it requires neither biopsy nor treatment. It is self-limiting, although the strand may persist for longer than a few months.

The main interest of this entity is that Mondor's disease presents as a quite distinctive picture. There is nothing like it found elsewhere in the body. Thrombo-phlebitis is one of the commonest human ailments and parental therapy has made it more so, yet nowhere else does an irritated vein behave in such a fashion. For this reason alone it seems wise to call it by a distinctive name and Mondor has the preference. The nearest approach in the body to the feel of this cord-like structure is the vas deferens or that occasionally found extending from the front of the lower fibula on to the dorsum of the foot when the superficial or cutaneous branch of the common peroneal nerve is palpable.

In the absence of any known etiological factors as to why so distinctive a clinical condition should occur in the overwhelming proportion of cases in the breasts of young and middle-aged women, it is suggested that 2 factors are operative which may have a bearing on the genesis of this phlebitis:

1. The breast is the only organ on the surface of the body where the physiology of the menstrual cycle results in a periodic turgescence followed by subsidence in the size of the gland.

2. It is universal in the social group affected that a brassiere is worn which is frequently tightly applied.

Do these factors operate in conjunction to lead to a variation in the pressure to which the subcutaneous veins are subjected and so cause stasis with clotting of the blood in the vessels?

Apart from infection, the commonest causes of phlebitis are immobility of the related part and interference with the venous return, hence the 'donkey' is no more used. These factors are both operative in the breast when a tight brassiere is used and it is suggested that they are factors in the genesis of Mondor's disease.

SUMMARY

1. Mondor's disease presents as a cord-like structure immediately under the skin of the breast.
2. It is rare and affects usually young and middle-aged women.
3. The cause is unknown. It is quite distinctive clinically, self-limited and innocuous and requires no treatment.

OPSOMMING

1. Mondor se siekte doen hom voor as 'n koordagtige struktuur wat onmiddellik onder die vel van die bors lê.
2. Dit is 'n seldsame kwaal wat gewoonlik jong en middelbare vroue aantast.
3. Die oorsaak is onbekend. Klinies is dit heeltemal kenmerkend, selfbeperkend en onskadelik, en dit hoef nie behandel te word nie.

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5. Kaufman, P. A. (1956): *Subcutaneous Phlebitis of the Breast and Chest Wall*, Ann. Surg., **144**, 847.
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PROGRAMME OF MEETINGS

*Jobannesburg, Transvaal, South Africa**9 to 24 February, 1959**President:*

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Secretary-General:

A. J. ORENSTEIN, M.D., D.Sc., LLD.,
F.R.C.P.

Assistant Secretaries General:

C. G. HIDE, F. A. SNYMAN

Monday, 9 February

- 10.00 a.m. Official Opening. Visit Chest Clinic.
 2.15 p.m. Visit Pathology Division. Meeting of Bureau.

Tuesday, 10 February

- 9.00 a.m. Visit Pneumoconiosis Medical Bureau and Physiology Division.
 2.15 p.m.
 1.01 The physical and chemical properties of silica, silicates and modified forms of these in relation to pathogenic effects.
 Dr. G. Nagelschmidt.
 1.02 The bio-assay of dust with particular reference to experimental methods.
 Prof. A. J. Vorwald.
 1.03 Animal experiments on important parameters of dust in relation to production of fibrosis.
 Dr. B. Goldstein.
 1.04 Respiratory dust retention, and elimination.
 Prof. T. F. Hatch, Dr. W. Walkenhorst.

Wednesday, 11 February

- 9.00 a.m.
 2.01 The significance of submicroscopic particles in the pathogenesis and pathology of silicosis.
 Prof. A. J. Vorwald.
 2.02 Relation between lung pathology and lung dust analysis.
 Dr. G. Nagelschmidt.

- 2.03 Methods of correlating information concerning dust with pathological criteria.
 Mr. D. G. Beadle.
 2.04 What should be measured in dust sampling.
 Dr. A. J. Orenstein.
 2.15 p.m.
 2.05 The pathology of gold miners' silicosis.
 Dr. I. Webster.
 2.06 The bronchi in silicosis.
 Dr. C. B. Chatgidakis (Pathology),
 Dr. G. Worth (Clinical),
 Prof. F. Lavenne.
 2.07 Emphysema in relation to silicosis.
 Prof. J. Gough.

Thursday, 12 February

- 9.00 a.m.
 3.01 The heart in silicosis. Cor pulmonale.
 Prof. B. J. B. Becker, Prof. F. Lavenne.
 3.02 The pathogenesis of cor pulmonale: the respective influence of vascular changes and ventilation impairment.
 Prof. F. Lavenne.
 3.03 The correlation between E. C. G. criteria, clinical manifestations and necropsy findings in silicosis.
 Dr. B. van Lingen (Clinical),
 Dr. C. B. Chatgidakis (Pathology),
 Prof. F. Lavenne.
 3.04 Correlation of radiological and necropsy findings in silicosis.
 Dr. M. Hurwitz (Radiology),
 Dr. J. C. Wagner (Pathology).
 3.05 Pathological, clinical and radiological aspects of asbestosis.
 Dr. J. C. Wagner (Pathology),
 Dr. C. A. Sleggs (Clinical),
 Dr. M. Hurwitz (Radiology).
 2.15 p.m.
 3.06 The part played by free silica in the pathogenesis of coal workers' pneumoconiosis.
 Dr. G. Nagelschmidt.
 3.07 The role of infection in pneumoconioses.
 Prof. J. Gough.

- 3.08 Experimental infective pneumoconiosis.
Prof. E. J. King.
- 3.09 The clinical and epidemiological aspects of the role of tuberculosis in pneumoconiosis.
Dr. A. Meiklejohn.

Friday, 13 February

- 4.01 Immunological approach to silicosis.
Prof. E. C. Vigliani,
Dr. I. Webster.
- 4.02 Pathology of rheumatoid silicosis.
Prof. J. Gough.
- 4.03 Scleroderma in gold miners.
Dr. L. D. Erasmus.
- 4.04 Effect of colloidal silica on tissue respiration.
Dr. F. M. Engelbrecht.
- 2.15 p.m.
- 4.06 The chemical approach to therapy of pneumoconiosis.
Dr. D. A. Sutton.
- 4.07 The therapy of silicosis.
Dr. G. K. Sluis-Cremer.

Saturday, 14 February

- 9.00 a.m.
- 5.01 The chemical changes induced by fibrogenic and inert dusts.
Dr. D. A. Sutton.
- 5.02 Mucopolysaccharides and lipids in the lungs of experimental animals.
Dr. D. A. Sutton.
- 5.03 Proteins in the lungs of experimental animals.
Dr. D. R. Cooper.
- 5.04 Amino acids in the lungs of experimental animals.
Mr. P. Baily.
- 5.05 Histochemistry of Silicotic Island Formation.
Dr. I. Webster,
Dr. W. J. Pepler.

Monday, 16 February

Visit Gold Mine.

Tuesday, 17 February

9.00 a.m.

- 6.01 Pneumoconiosis related to—
(a) dust exposure, (b) occupation,
(c) age.
Dr. J. McG. Rogan.
- (d) radiological category, (e) progression.
Dr. J. C. Gilson.
- (f) Statistical studies thereon.
Dr. A. J. B. Wiid.

- 2.15 p.m.
- 6.02 The value and limitations of pre-employment and periodical examinations in South African experience.
Dr. J. H. Loots.
- 6.03 Comparison of the value of 35 mm. films and full size radiographs in the early detection of silicosis.
Dr. J. A. Louw.
- 6.04 The radiographic recognition of early nodule formation in silicosis.
Dr. C. P. Theron.
- 6.05 How much physiological information can be obtained from a plain radiograph.
Prof. E. Samuel.

Wednesday, 18 February

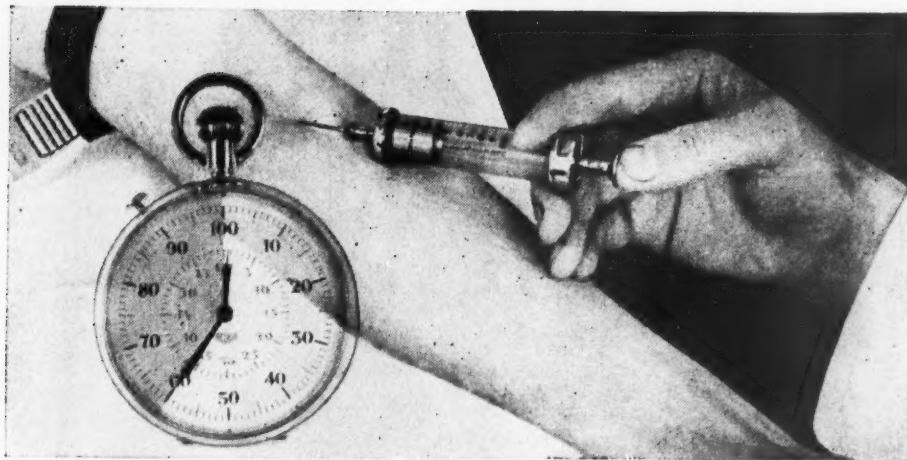
- 7.01 Changes in clinical, pathological and radiological findings due to ageing.
Dr. J. C. Gilson (Clinical),
Prof. J. Gough (Pathology),
Prof. E. Samuel (Radiology).
- 7.02 Radiological appearances of the more common pneumoconioses and of other conditions which simulate them.
Dr. O. A. Sander.
- 7.03 Assessment of pulmonary disability.
Prof. P. H. Rossier, Prof. F. Lavenne.
- 7.04 The effect of continuing in original dusty occupation on the progression of pneumoconioses.
Dr. O. A. Sander.
(There may be a statistical contribution by Dr. A. J. B. Wiid.)
- 2.15 p.m.
- 7.05 What advice should be given a person in the early stages of—
(a) silicosis, (b) coal workers' pneumoconiosis, (c) asbestosis, (d) other pneumoconioses.
Dr. A. Meiklejohn.
- 7.06 Psychological aspects of silicosis.
Dr. G. K. Sluis-Cremer.
- 7.07 Pulmonary function tests on silicotics in South Africa.
Dr. S. Zwi.
- 7.08 Relation between clinical findings and pulmonary function tests in pneumoconiosis.
Dr. B. van Lingen.

Thursday, 19 February

- 8.01 Differentiation of pulmonary and cardiac dyspnoea by pulmonary function tests.
Dr. R. Kaminer.
- 8.02 Appraisal value of effort tolerance tests.
Dr. C. H. Wyndham,
Prof. F. Lavenne,
Dr. G. K. Sluis-Cremer.

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- 8.03 Therapy of tuberculosis associated with silicosis.
Dr. M. A. Pringle.
- 8.04 The problem of 'idiopathic' pleural effusion.
Dr. S. J. Fleishman.
- 2.15 p.m.
- 8.05 Somatotype and pneumoconiosis.
Dr. B. van Lingem.
- 8.06 Incidence of silicosis in siblings.
Dr. G. K. Sluis-Cremer.
- 8.07 Hypertension and coronary disease in pneumoconiosis.
Dr. H. D. Jacobs, Prof. F. Lavenne.

DUST ENGINEERING GROUP

Thursday, 12 February

(To continue on subsequent days, as may be arranged by the Group itself.)

- 9.00 a.m.
- 9.01 History of dust measurements.
F. G. Hill.
- 9.02 The objects of dust measurement.
Mr. D. G. Beadle.
- 9.03 Methods of dust measurement.
Mr. P. H. Kitto, Dr. W. Walkenhorst.
- 9.04 The strategy of dust sampling for—
(a) routine and (b) research.
Mr. R. J. du Toit.

- 9.05 Sources of dust and methods of prevention at the source.
Mr. J. de V. Lambrechts.
- 9.06 (a) Behaviour of mine dust; (b) its control.
(a) Dr. H. S. Sichel, Mr. M. Barcza,
(b) Mr. W. le Roux.
- 9.07 Present methods of decreasing exposure to dust.
Mr. T. L. Gibbs, Dr. W. Walkenhorst.

Friday, 20 February

Complete any unfinished discussions.
Official closing of Conference.

POST-CONFERENCE MEETINGS

Saturday, 21 February

- 9.00 a.m.
Meeting of Chairmen and Reporters to draft findings and recommendations.

Monday, 23 February

- 9.00 a.m.
Plenary Session to discuss the findings and recommendations.

Tuesday, 24 February

- 9.00 a.m.
Adoption of findings and recommendations.

A FURTHER STUDY OF THE ANTIQUITIES IN RELATION TO MEDICINE, SURGERY AND GYNAECOLOGY

AYRES L. RIBEIRO, M.A. (CAMB.), L.R.C.P. (LOND.), M.R.C.S. (ENG.)
Nairobi, Kenya

A further study of the antiquities reveals some unusual, comic and bizarre aspects of medicine.

THE PHYSICIAN AS PORTRAYED ON THE THEATRE STAGE

It is realized by very few that the physician was portrayed in the comedy of arts and in melodrama, in the 16th, 17th, and 18th centuries, and was considered to be a most amusing character.

The 'Doctor' appeared on the comic stage soon after the evolution of the religious plays (in the Middle Ages) into the 16th century comedy.

The 'Doctor' was meant to be a character who was entrusted with the task of parodying

medicine and the academic sciences. He was sometimes also considered to be a charlatan who sold his potions and skill by his eloquence and the credulity of his listeners.

The 'Doctor' was dressed on the stage in a typical costume, as illustrated in Figs. 1, 3 C, 4 C. This consisted of a black suit with a white collar, a mask and a large brimmed hat. His chief characteristic was that of always being in error with a constancy that evokes admiration. He was supposed never to make a correct diagnosis, not even by chance. Again, his pomposity and sureness of himself are typified in such lines as when he declaims: 'Not one of my patients has ever died.'

Phrases such as 'He who is always wrong, is never right' or 'A ship on the high seas is distant from the shore,' and other such



Fig. 1. All these porcelain statues belong to the mid-18th century period.

- A: The Doctor (*Il Dottore*). Maschera della Comedia Italiana. Dipinto di A. Carraci.
- B: Medicine.
- C: Maestro Spinellocchio in *Gianni Schicchi*.
- D: Dulcamara in *L'Elisir d'Amore*.
- E: Don Bartolo in *The Marriage of Figaro*.
- F: The Doctor in Busoni's *Harlequin*.
- G: The Doctor in the act of declaiming.
- H: The Doctor, masked and dressed according to custom.
- I: Chelsea porcelain figure of The Doctor from the *Italian Comedy*, 1775-1780.

sayings, were another illustrative characteristic of the 'Doctor' in argument.

The physician was also presented satirically. Thus were born the characters of Dulcamara in *L'Elisir d'Amore*, Don Bartolo in the *Marriage of Figaro*, Maestro Spinellocchio in *Gianni Schicchi* and the 'Doctor' in Busoni's *Harlequin* (Fig. 1). He was portrayed as a skilled psychologist, a twister and a successful rogue, rather than a purveyor of wonderful elixirs.

FEAR AND DEVASTATION DUE TO EPIDEMIC DISEASES

The most dreaded diseases in Europe were cholera and plague (Figs. 2 and 3 B). Pedlars sold various prophylactics. Men and women wore strange devices to keep off cholera. The cartoon by Cruickshank (Fig. 2 A) depicts the cholera pie, being cut with the lancet (knife).

Cholera spread rapidly everywhere. Over 1,000 persons died every day in the large cities. Nobody knew how the disease was transmitted. Neither did anybody know how to cure it. This problem was a hard nut (Fig. 2 G), which needed a magician to crack it. The magician did arrive and cracked it. His name was Robert Koch.

The picture about the plague (Fig. 3 B) shows a house marked with a red cross, a woman with a baby in her arms, dying; and a cart full of corpses. Above all, the finishing touch is given by showing the man who has come to collect the dead, to pile them on the cart, shouting: 'Bring out your dead, bring out your dead.' It is not surprising that everyone lived in dread and fear of these epidemic diseases, which devastated whole cities and populations.

MEDICINE AND SURGERY IN FAMOUS PAINTINGS

From the times of ancient Egypt to the present day, much of medicine and surgery has been depicted in famous pictures. The apotheosis was the Renaissance, leading into the Baroque and the Rococo periods. Regarding the pictures of the last century, there is the famous painting, *The Doctor*, by Sir Luke Fildes, R.A., exhibited at the Royal Academy in 1891, which now hangs in the Tate Gallery, London. This painting was originally called *The Crisis*, and was used on a postage stamp by the American Medical Association to commemorate their Centenary in 1947.



Fig. 2. All these lithographs on cholera were engraved in France, Germany and in England during the epidemic of 1828-1838.

- A: Cholera cartoon by Cruikshank.
- B: Traveller in anti-cholera prophylactics recommending his wares.
- C: Anti-cholera protection for men.
- D: Anti-cholera protection for women.
- E: The cholera chooses its victims.

- F: A medieval doctor visiting his patients, accompanied by his assistants.
- G: Cholera depicted as a hard nut to crack.
- H: The young Athenian soldier or *Ephebos*.
- K: The physician Phillipos attending to Alexander The Great at the Palace of Babylon. An 18th century print.

Figs. 4 A and 5 show some famous paintings by famous artists dealing with medicine and surgery. The grafting of a negro's leg on to an amputee (Fig 4 A) makes one speculate a lot about the state of surgical knowledge of those days. There is no doubt that these two surgeons, Saints Cosmos and Damian, were successful in the practice of surgery and medicine, because another painting (Fig. 5 A) depicts their being well paid for their services in medicine and surgery.



Fig. 3 A: Extraction of St. Ignatius' heart (Painter, Sandro Botticelli).
B: The Great Plague. (Note the cart full of corpses).
C: Preparations for a performance. (18th century Venetian school). The doctor is in the background on the left with his typical hat and about to declaim.

Fig. 5 B, *An Operation*, by Adriaen Brouwer, is very interesting. The long, wailing howl of the patient, the impassive concentration of the surgeon, and the detachment of the assistant, who is holding a dressing in his hand, are well worth careful study.

The Sick Man (Fig. 5 E) is by Sebastian de Piombo. The expression on the face of the patient, and the chiaro oscuro technique, are masterpieces of the painter's art.

Finally, the extraction of St. Ignatius' heart (Fig. 3 A) reminds one of the customs of the Middle Ages, when important persons had different parts of their body buried in different places.



Fig. 4 A. Saints Cosmos and Damian affix a negro's leg to an amputee. (Painter, Beatico Angelico).

B: Dr. Ratcliffe of Alstrop Spa, denying the charge of paternity in the presence of the parish officers.

C: Masques of the Italian Comedy dancing. (Oil painting of the 16th century Venetian school—a detail). The Doctor turns to a group of seated ladies and invites them to dance. He is wearing a mask in the traditional fashion.

7 February 1959

MEDICAL PROCEEDINGS · MEDIESE BYDRAES

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[Advertisement]

WATSON ODELCA

RADIOGRAPHIC EQUIPMENT
FOR PNEUMOCONIOSIS DIAGNOSIS
IN

SOUTH AFRICA



Represented in South Africa by

THE BRITISH GENERAL ELECTRIC CO. (PTY.) LTD

The Pneumoconiosis Act of 1956 imposed on the established X-ray apparatus suppliers, in the Union of South Africa, a sudden demand for specialized equipment on a scale never before experienced in any country.

The purpose of this publication is to explain how this demand for the major part of the equipment purchased by the Mining Industry was met by the British General Electric Co. (Pty.) Ltd., and to pay a tribute to the authorities, whose foresight and interest in the mineworkers' welfare brought about this notable undertaking. A tribute is also paid to the Mining Industry for the manner in which its members adapted their complex organization to handle the numerous radiographic examinations with such efficiency.

Without Force of Legislation, the Witwatersrand Native Labour Organization has for many years carried out, on behalf of the Mining Industry, a continuous mass X-ray survey of entrants. The pioneer work of this branch of the Chamber of Mines, and their Engineer, Mr. K. G. F. Collender, has received world-wide recognition.

The accompanying photographs illustrate the special plant in current use at the W.N.L.O. This equipment was manufactured by Watson and Sons (Electro-Medical) Ltd., to the speci-

fication of Mr. K. G. F. Collender and was installed, and is maintained, by the British General Electric Co. (Pty.) Ltd. This specialized installation has accomplished, to date, over 1,000,000 exposures without serious breakdowns, and has exceeded 3,400 examinations in one morning, with all radiographs processed, dried and written up by the radiologists before lunch. The 6 Machlett X-ray tubes have averaged over 150,000 exposures. Never once has a group of Native entrants been held over to the following day through faulty apparatus.

The equipment comprises 3 Watson Cameras, fitted with Taylor Taylor Hobson f/1.5 lenses. The odd and even number tubes are energized in the order of 1, 3 and 5 simultaneously through a 3-phase supply, with the exposures on 2, 4 and 6 following immediately. A compound X-ray apparatus, utilizing three 200 mA high tension transformers each coupled to 2 Machlett Dynamax 25 rotating anode tubes, is employed. Separate control tables permit individual operation, if required. A central robot control is provided for normal use when all the tubes are employed. Exposures are individually controlled through photo-timers.

Film identification has been achieved by a unique system designed by Mr. Collender.

A full description of this plant has been published elsewhere, notably *Radiography* (Vol. XXII, No. 260, August 1956). The establishment has also been the subject of lectures at International Conferences.



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Choice of Equipment by the mines has ranged from installations permitting teleradiography, where numbers of employees are small, to mass chest survey units employing either Watson Odelca 70 mm. or 100 mm. installations. Watson Odelca cameras have been exclusively supplied with the installations carried out by the British General Electric Company (Pty.) Ltd. These incorporate the Bouwers' concentric mirror system developed by Dr. A. Bouwers, who is famous for his many contributions in the field of radiographical equipment.

The choice of 70 mm. or 100 mm. size was largely a matter of individual preference or of economic considerations, although the 100 mm. size film was mainly favoured. The results with both systems have been found highly satisfactory.

The accompanying illustrations show various installations, chosen by certain users to meet their needs.

A Typical Installation incorporating the Watson Odelca 100 radiographic camera unit is featured opposite, together with a layout drawing of the room in which it is housed. This installation has been highly praised by

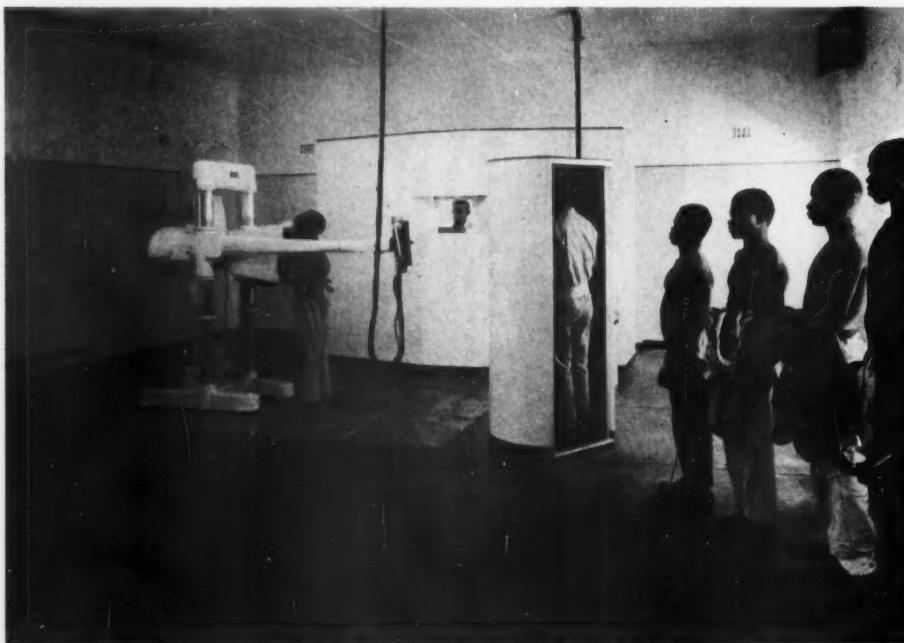
overseas authorities as well, and the layout of equipment prepared by the consultant, Mr. K. G. F. Collender, has been remarked upon as an excellent arrangement.

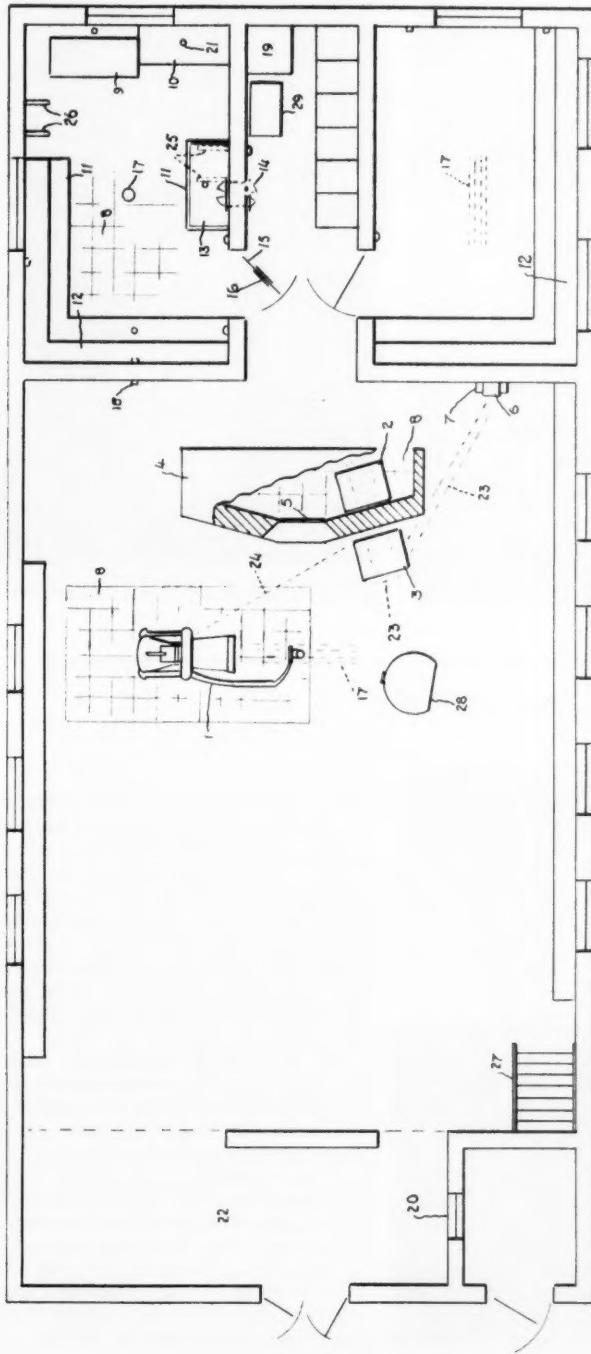
The Watson twin column power assisted stand is undoubtedly the best of its kind; the massive camera being adjusted to patient height with little effort on the part of the operator. The rate of camera travel is proportional to the pressure applied to the operating arm and the control is delightfully sensitive.

Most of these stands are fitted with a tube support arm which carries the X-ray tube precisely at the correct distance and alignment. In some cases provision is made for direction of fire of the X-ray tube to be easily reversed so as to permit teleradiography with full size films without employing an additional tube stand and tube.

Still another variation allowed the camera to be coupled with a tube mounted on an additional tube stand and this provides means for carrying out general radiography as well as the miniature film chest examinations with one X-ray generator.

(Photograph by courtesy of the Manager, West Rand Consolidated Mines Ltd.)

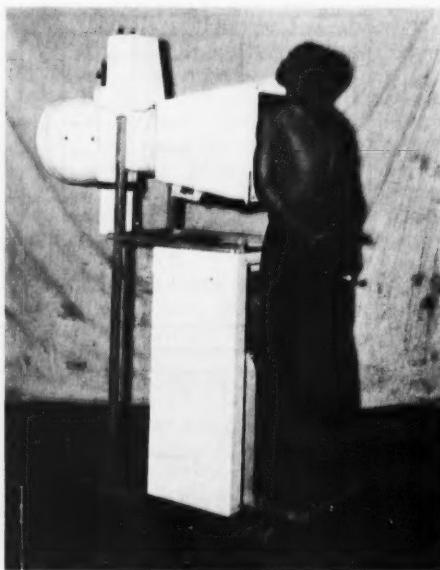




- 1 100 mm. unit.
- 2 Control table.
- 3 H.T. transformer.
- 4 Protective cabin.
- 5 Lead glass window.
- 6 Wall contactor.
- 7 Junction box.
- 8 Rubber floor.
- 9 Processing unit.
- 10 Sink.
- 11 Dry bench.
- 12 Shelves every 2 ft. 0 in.
- 13 Rubber mat.
- 14 Change hatch.
- 15 Double rabbed door.
- 16 Louvre.
- 17 Ceiling lights.
- 18 15 Amp plugs 5 ft. from floor.
- 19 Cooling unit 7 ft. from floor.
- 20 Issue of cards window.
- 21 Pendant plug & ceiling switch.
- 22 Upstairs stores.
- 23 Channel.
- 24 Conduit.
- 25 Hangers 12 in. x 15 in.
- 26 Hangers 12 in. x 15 in.
- 27 Steps.
- 28 Cubicle.
- 29 Drying cabinet.

In the Several Cases where there were advantages in adopting a fixed camera height this was achieved by what is commonly called a Patient Platform Stand.

The illustration opposite is of such a Hydraulic Stand which was designed and manufactured in the Union of South Africa. With it the examinee is raised to the required height by a hydraulic ram acting on a platform assembly. The ram is fed with a special fluid from a pump driven by an electric motor which is switched on whenever the operating handle is raised. This handle is discernible at the right of the model. The patient is lowered by depressing the operating handle which allows the fluid to flow back to the reservoir due to the patient's weight. This movement may be varied from a slow creep to a rapid decline at the discretion of the operator.



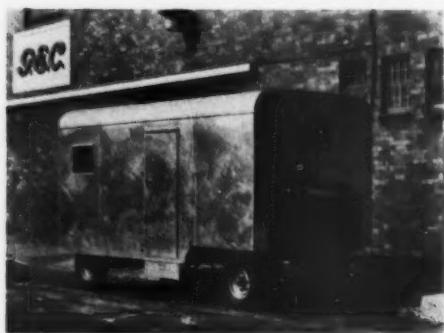
Where the Compounds housing the native mineworkers are widespread on any mining property, or where one X-ray unit has to serve more than one mine, equipment has been installed in vehicles of the trailer type,

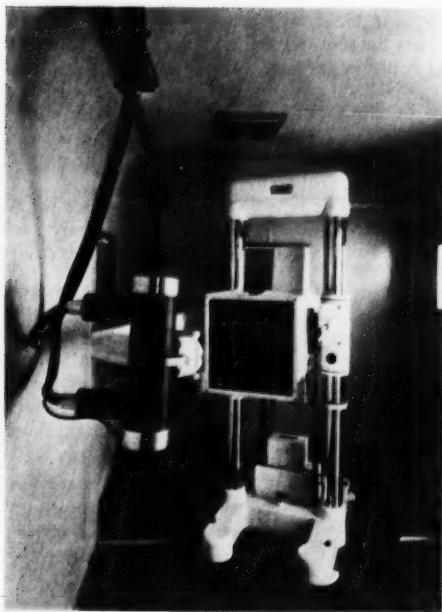
These vehicles are towed from centre to centre to coincide with the times at which chest examinations are conducted at the various points.

The illustrations provide an example of one type of vehicle in which X-ray equipment has been installed. Various alternative designs of vehicles and vehicle trailers are available, which may incorporate facilities for processing the X-ray films, if the internal arrangements of the vehicle and X-ray installation permit, and the vehicle is designed to suit.

In the vehicle illustrated, only photofluorographic chest examinations are conducted and the X-ray film is processed at a central darkroom, to which the exposed films are despatched from time to time.

When a suitable power supply is not available at examination centres, a diesel or petrol driven generator set may be towed on a trailer, for use with the X-ray apparatus whenever it is required. Normally the mobile X-ray units employed on the mines are connected to adequate electricity mains supplies by a trailing cable contained within the vehicle.



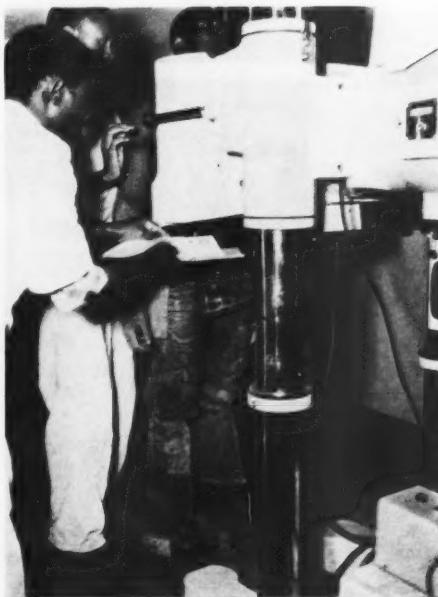


FILM IDENTIFICATION

Whilst the Standard Odelca arrangement satisfied most requirements, considerable ingenuity has been displayed in the manner in which this has been employed.

Several mines employ a normal large size Serial Numbering Stamp—others use cards previously numbered. In another a supply of cards is kept when two or more are used together to build the required number and code. These cards, of course, are indefinitely reusable. Dates and mine codes that are common to all examinees are provided by the use of stencil type absorption markers mounted on the camera face so that the resultant image appears over each shoulder.

The illustration shows the examinee being positioned for photofluorographic examination whilst an assistant places a card in the Patient Identification Card Holder. The number appearing on the card is recorded on the film through a photo-electric cell unit incorporated in the camera.



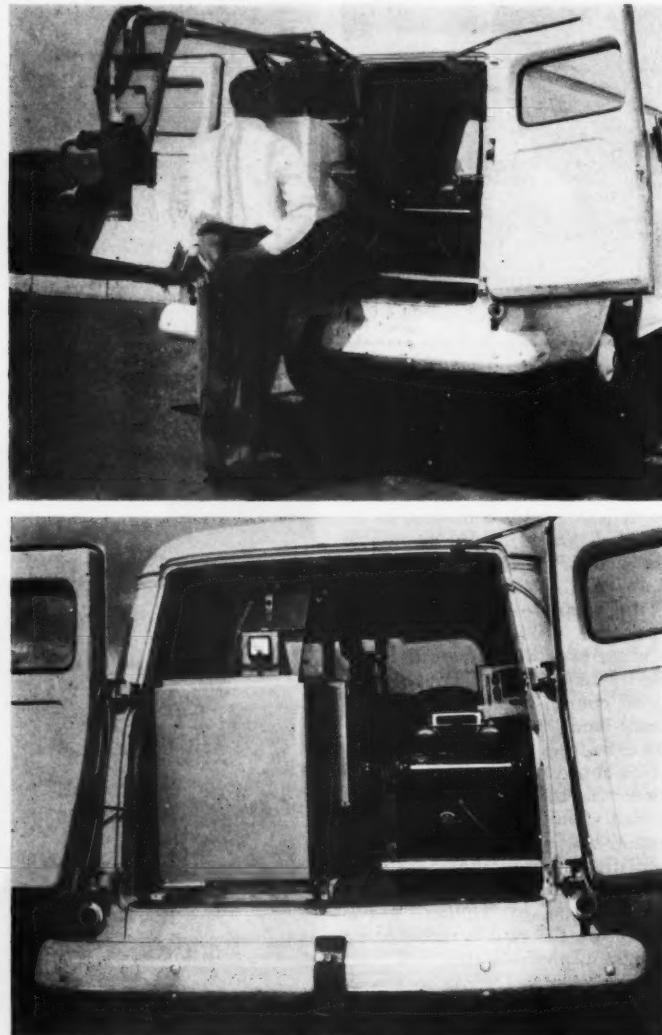
When it is Desired that X-ray equipment be mounted in a vehicle other than a truck or trailer, this may be achieved by an installation of the type illustrated.

A panel van with extra-long wheel base may be employed, and the Watson Odelca radiographic camera unit is arranged to permit the examinee to stand on the ground behind the van whilst the camera height is altered to suit his height.

This 'Spring-Poise' unit was specially designed and developed in this country by the

British General Electric Co. (Pty) Ltd. to meet the requirements of a specific user. Whilst it is not employed in the detection of pneumoconiosis specifically, this method of providing a mobile X-ray unit may be used more widely in the field, where long distances have to be travelled by medical and research groups in combating tuberculosis.

A diesel or petrol operated generator set on a light 2-wheel trailer may be towed by such a panel van, to furnish the required electricity supply.



X-RAY GENERATORS USED

In Britain where blue sensitive screens are favoured, because of their speed, 100 milliamperes are considered an adequate tube current for satisfactory miniature film radiography. A number of units of this size have been installed and these are of the Watson 'Roentgen 100' self-rectifying type.

More usually, however, it was felt that 200 mA units would carry a greater reserve of power to deal with the larger physique common in South Africa amongst Europeans. In a great many cases this was achieved by adding to the 'Roentgen 100' unit a full wave rectification unit featuring the highly efficient low loss long life Machlett Thoriated filament rectifiers.

In other examples, the Watson 'Roentgen 200' Generator was employed with still another variation when facilities for full size radiography was required, in which case the units were set up for alternative 300 mA operation.

Normal time switches are incorporated in all units and permit exposures times to be

controlled by the operator, if required, but invariably their employment is as a limiting switch to the Photo Timer, which controls exposure times according to the intensity of radiation reaching the fluorescent screen.

All units were equipped with milliampereseconds meters—considered by us to be an important instrument in mass radiography as it provides the most effective method of ensuring that each exposure is made with the appropriate amount of radiation. It enables, also, a ready check to be made of the operators' output at all times, by using a metal phantom which will give a known mAs value at a standard setting of the control.

In addition to the several variations of the Watson range of generator employed, some installations were carried out with existing generators of other manufacture. In such they were adapted to accept Rotating Anode Tubes and circuitry was added to operate the camera drive and safety interlocks. All these conversions have proved satisfactory and represented a significant economy.

The Application of Mass Miniature Radiography Surveys in the Mining Industry is noteworthy but it is even more striking when one observes that at the Third International Congress of Photofluorography in Stockholm, 1958, the fact was impressed that, in countries where mass miniature surveys are periodically carried out, tuberculosis rapidly declines.

In South Africa, welfare organizations and government bodies have been employing

photofluorographic techniques in combating pulmonary tuberculosis and, with the major contribution of the Mining Industry, it is possible that tuberculosis will be eradicated.

The greater interest being taken in this work throughout the world has resulted in the manufacturers of Watson Odelca radiographic camera equipment providing a wide range of apparatus suited to all practical applications of photofluorography.

Index to some Users of Watson Odelca Installations in South Africa**Anglo American Corporation of South Africa Limited**

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Brakpan Mines, Limited.
Cornelia Colliery.
Coronation Collieries.
Daggafontein Mines, Limited.
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[Advertisement]

The apparatus described was installed by a team of engineers under the leadership of Mr. A. E. Briant.

It was apparent that this team would encounter technical problems in dealing with the new types of equipment, and, to ensure that they would be competent to deal with these situations, 5 of our service organization visited the Watson and 'Oude Delft' factories for special instruction from the designers and manufacturers of the apparatus including the 'Odelca' Cameras.

This experience was extended during the actual installations carried out in this country, and present and future users of Watson Odelca equipment are assured of a competent and knowledgeable service at all times.

THE BRITISH GENERAL ELECTRIC CO. (PTY.) LTD

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DRINKING CUPS

Three varieties of ancient drinking cups are of medical interest and are rarely acquired nowadays because they are very scarce and in great demand by collectors. Figs 6 C—6 E depict these cups, which were supposed in the Middle Ages to have mysterious and powerful medicinal properties against rheumatism and poison. The coconut cup and the ostrich cup



Fig. 5 A. Saints Cosmo and Damiano receive their recompense for practising medicine.

B: An operation (Painter, Adraen Brouwer, The Louvre, Paris).

C: Sick persons praying for recovery (Painter, Taddeo Gaddi).

D: The doctor's visit. (Painter, Pietro Longhi, Correr Museum, Venice).

E: The sick man. (Painter, Sebastian di Piombo).

F: Tobias heals his father. (Painter, Gregorio Pagani).

were supposed to be anti-rheumatic. The crystal cup was supposed to crack if poison were put into it.

All three cups illustrated (Figs. 6 C—6 E) are masterpieces of the silversmith's art and craft. A wonderful amethyst cup was supposed to have belonged to John of Gaunt, Duke of Lancaster. It was destroyed when the Savoy Palace in the Strand, London, was burnt down during Watt Tyler's rebellion.

The jar with the inscription *Theriaca* (Fig. 7 B) is a wonderful example of an apothecary's jar of that period. Many a beautiful lady stored her cosmetics and medicines in such a jar, and guarded her wares carefully, so that she might appear as shown in Fig. 8 D. Naturally, riches, leisure and contentment were also essential ingredients in beauty's medicine. The text (a recipe for beauty) reads:

'That which above all things makes a woman beautiful, is the fact of having riches, few cares and happiness, as poverty, worry and sorrow, are the three things which would age a person of even 15 years, so that all the cosmetics in the world would not be sufficient to make her appear beautiful. When the heart is afflicted, the face appears grief-stricken, the eyes sad and anguished, and in order to make an ugly woman pretty, there is nothing else to do, but to find her a rich husband who loves her, so that she will not have too many cares in the home and will always be happy. This is the true cosmetic which makes all ugly women appear beautiful. In fact, you may choose as beautiful a woman as you wish, and then subject her to poverty, sorrow and torment—she will appear ugly.'

When a woman wishes to appear beautiful, she should always try to be happy, for, as the proverb says, *A happy heart makes a beautiful complexion*. When a woman is happy, it is much easier for her to beautify herself.

Cosmetics will be of great aid, for if she is dark-skinned, they will make her fair; if pallid, rosy; and if wrinkled, smooth-skinned. However, as I have previously stated, it is necessary that she does everything to keep her smiling face, for she will thus become beautiful.'

FROM A MAGAZINE OF 1832

Interesting anecdotes are told in a magazine called *The Doctor*, which was supposed to be read by 'clergymen, heads of families, nurses, etc.' One of the anecdotes (Fig. 8 C) is called *A Physician's Hint Taken*, and is described as follows:

'Sir Richard Jebb used to tell a story of himself, which made even rapacity comical. He was attending a nobleman, from whom he had the right to expect a fee of five guineas. He received only three. Suspecting some trick on the part of the steward from whom he received it, he, at the next visit, contrived to drop three guineas. They were picked up and

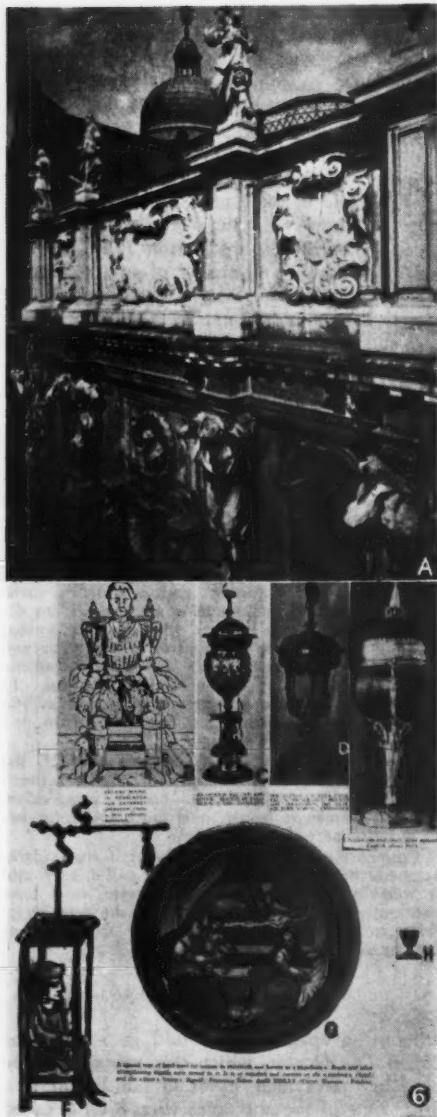


Fig. 6 A. Ospedaletto founded in 1181 for the Crusaders. Rebuilt in the 16th and 17th centuries, and now an orthopaedic hospital.

B: Patient bound in readiness for a cataract operation. 16th century woodcut.

C: An ostrich egg cup.

D: Crystal cup.

E: Coconut cup.

F: The first basal metabolic machine by Professor Sanctorius of Padua, 1614.

again deposited in his hand. But he still continued to look on the carpet. His lordship asked if all the guineas were found. 'There must be two still on the carpet,' replied Sir Richard, 'for I have but three.' The hint was taken as he meant.'

Another story is told of *How to Discover Convalescence* (Fig. 8 A). The following conversation once passed between the physician Bouvart and a French marquis, whom he had attended during a long and a severe indisposition. One day, when the former called, he was thus addressed by the marquis:

'Good day to you, Mr. Bouvart. I feel quite in spirits and think my fever has left me.' 'I am sure of it,' replied the doctor, 'Your very first expression convinced me of this.'

'Pray explain yourself.'

'Nothing easier. In the first stage of your illness, when your life was in danger, I was your dearest friend. As you began to get better, I was your Bouvart; and now I am Mr. Bouvart. Depend upon it, you are quite recovered.'

During the 17th, 18th and 19th centuries, cinchona bark used to be prescribed in port wine. A story is told in the same magazine about *Port Wine and Bark* (Fig. 10 C):

A young lady's physician prescribed port wine and bark to be taken every day. His advice was followed, inasmuch as the patient drank the wine, and ran about the house barking like a dog. Upon being remonstrated with for such folly, she very coolly stated: 'Why, the doctor told me to take port wine and bark.'

Another story is told about Dr. Ratcliffe in the same magazine (Fig. 4 B):

The waters of Alstrop, near Brackley in Northamptonshire, were, in his time, in fashion and were strongly recommended by Drs. Willis and Lower. Unfortunately, on Dr. Ratcliffe's spending some time at these wells, a woman of the village becoming pregnant, and being called before the parish officers to filiate the child, laid it upon Dr. Ratcliffe, who was highly indignant at the charge and declared that if they charged him with the maintenance, he would put a toad in their well. The officers were inexorable; but the doctor coming into very great practice, so cried down the Alstrop waters, that they entirely lost their reputation. Otherwise, Alstrop would have been what Cheltenham is to-day.

AN ASSORTED MISCELLANY

The first basal metabolic machine was invented in 1614 by the famous Padua professor called Sanctorius (Fig. 6 F). A woodcut (Fig. 2 F) shows a mediaeval doctor visiting his patients with his assistants. Fig. 6 B shows a patient

G: A special type of bowl used for women in childbirth. Broth and other strengthening liquids were served in it. Majolica ware. Consists of *Piadena* (bowl) and the *Tajer* (cover), signed Francesco Xanto Avelli, 1530. (Correr Museum, Venice).

H: A faience apothecary's urn.

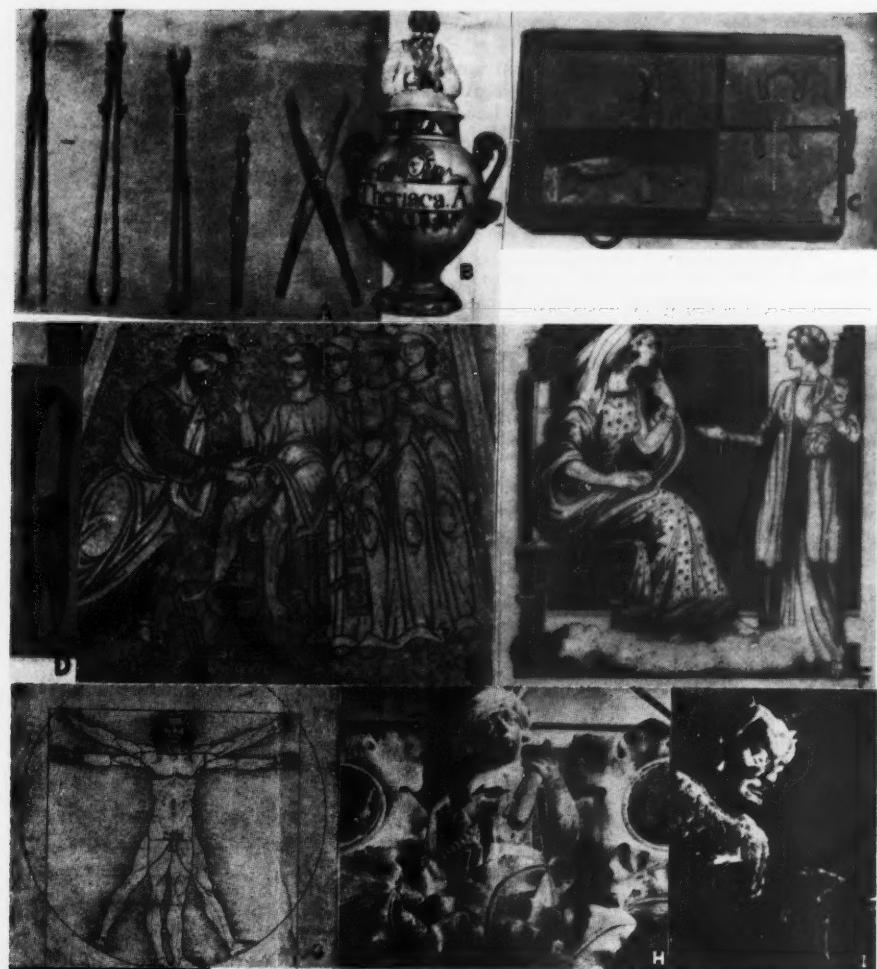


Fig. 7 A: Forceps. *At the extreme right:* A pair of clamp forceps. Forceps are the most common of all the Roman medico-surgical instruments which have been discovered. Their state of preservation is generally satisfactory. Some of these clamp forceps function even today.

B: Theriaca Jar.

C: Compartmented medicine chest for storing drugs. *Above:* Chest without its cover. Fragments of unidentifiable medicaments may be seen in the open compartment.

D, E: The circumcision of Ishmael.

F: Eileithyia. According to tradition it was the custom for expectant mothers, and women recently delivered, to spend one third of a hour daily in dedication to *Eileithyia*, the Greek Goddess of Childbirth, and to make offerings to her of toilet preparations and articles of attire.

G: Leonardo da Vinci. Geometrical anatomical drawing.

H: Barber with a razor. (Ducal Palace, Venice).

I: Sheng-Non. Sheng-Non is represented by an ancient figure with wrinkled brows and carrying two horn-like projections on his head. He is naked except for a pattern of leaves running over part of his body.

J: St. Rock pointing to a bubo.

bound in readiness for a cataract operation in the second half of the 16th century.

In Venice in the 18th century, nutrition was considered very important for women recovering from childbirth; hence the special bowl used for these purposes, called *Impallata* (Fig. 6 G). The Ospedalleto, founded in 1181 for the crusaders passing through the Holy Land, is now a specialized orthopaedic hospital (Fig. 6 A).

FAMOUS PAINTINGS DEPICTING MEDICAL SUBJECTS

Fig. 9 A is by Francisco di Stefano commonly known as 'Passellino' (1422-1457). It is called *The Surgeon Anatomizing the Corpse of the Miser*. It is a detail from *The Miracle of the Miser*, in the Uffizi Gallery in Florence.

Fig. 9 D shows an early 17th century painting by Franz van Mieris. It is called *The Sick Woman*. Fig. 9 B shows the treatment of madness by Hieronymus Bosch. It belongs to

the late 15th century. *The Surgeon* by Jan Sanders van Hemessen (Fig. 9 E) belongs to an earlier period in the same century. In this picture the interesting point is that the surgeon is using a huge knife with a curved handle. In contrast to the howling patient in Fig. 5 B, in this painting the patient, is a real 'patient,' suffering his ordeal calmly with patience and resignation. Note the expression and the *pince nez* on the surgeon's face.

Fig. 9 C depicts an apothecary's shop in the 15th century. The small lateral miniatures represent various heliotherapeutic and balneotherapeutic processes. The interesting painting, (Fig. 9 C i) shows the doctor in the act of making an examination of the chest. In Fig. 9 C ii, the doctor is bleeding the patient and Fig. 9 C iii shows an operation on the chest.

Fig. 9 F is a painting of the first half of the 18th century. It shows the doctor examining blood-stained urine in a flask. The patient has an ashen grey colour and appears not to have long to live.



Fig. 8 A. How to discover convalescence.

B: Fu-Hsi, one of the great Chinese Emperors, worshipped as a medical trinity in all Temples of Medicine in China (2953-2838 B.C.).

C: A physician's hint taken.

D: Beauty's medicine.

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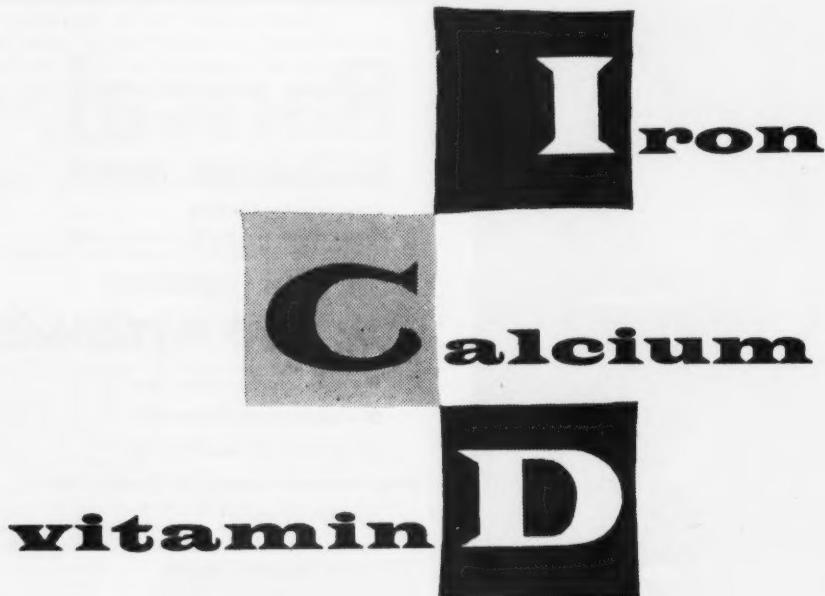
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ARABIC MEDICINE

Of the hundred and more philosophical works, now attributed to Avicenna (980–1037 A.D.), the *Canon* is undoubtedly the most important. Throughout the Middle Ages, and even later, this treatise was considered a fundamental work for the study of medicine; and in 1650 it was still used in the Universities of Louvain and Montpellier.

Although based on the medical texts of Hippocrates, Aristotle and Galen, the *Canon*

should none the less be considered an original work, because the doctrines of the aforesaid authors are reviewed and interpreted critically in the light of the Arabian philosopher's valuable experience and vast learning.

This work is divided into 5 volumes, of which the first and the second are devoted to anatomy, physiology, pathology and hygiene. The third, fourth and fifth describe the treatment of various diseases. The part dedicated to pharmaceutics is vast and valuable for its descriptions of new medicines, many of which are mentioned and tested for the first time by the author.

To confirm the importance of this classical medical textbook, suffice it to say that there were 30 or more editions, which followed the first Latin translation by Gerard of Cremona in the 12th century.

ANCIENT ROMAN MEDICINE

Many quacks and charlatans were attracted by the lights of ancient Rome, and flocked there to prepare and sell mysterious potions for every possible disease. There finally arrived the true, cultured physicians, some of whom acquired a good name and succeeded in entering the patrician houses, the colleges and the army.

Meanwhile, the first surgeries or *medicatriae*, as they were called, were opened, where the physicians visited the sick, medicated the wounded, applied bandages and taught the elements of medicine and surgery to their pupils.

It must not be thought that these physicians carried out major surgical operations. However, it is certain that emergency operations, even in the most serious circumstances, were earnestly attempted. In order to have an idea of the activities of the physicians of the first century A.D., i.e. at the period in which the imperial power of the Caesars was at its zenith, it is sufficient to look at two singular and fundamentally important pieces of evidence: one is the writings of Celsus, and the other the surgical instruments excavated at Herculaneum and Pompeii (Figs. 7 A–D).

The surgical treatment of wounds is one of the most highly developed chapters in Roman surgery. Celsus deals widely with this subject in his work and describes the various methods of treatment. If haemorrhages occurred, linen soaked in cold water was used to stem them. When this was not satisfactory, vinegar was applied and the vessels ligated. This was done by firmly tying all the surrounding tissue and by directly tying the bleeding vessel. Fig.



Fig. 9 A: Francesco di Stefano, called Pessolino. Surgeon anatomizing the corpse of the miser. (Florence, Uffizi Gallery).

B: Hieronymus Bosch, *Treatment of Madness*. (Madrid, Museum del Prado).

C: A painting by an Italian miniaturist, belonging to a manuscript of Avicenna's *Canon* (today preserved in the library of Bologna University).

D: Franz van Mieris, *The Sick Woman*. (Historical Art Museum, Vienna).

E: Jan Sanders van Hemessen, *The Surgeon*. (Madrid, Museum del Prado).

F: A doctor's visit. Doctor examining a flask of blood-stained urine.

7 A shows various types of forceps and clamps used by Roman surgeons in operations on wounds, for the extraction of foreign bodies.

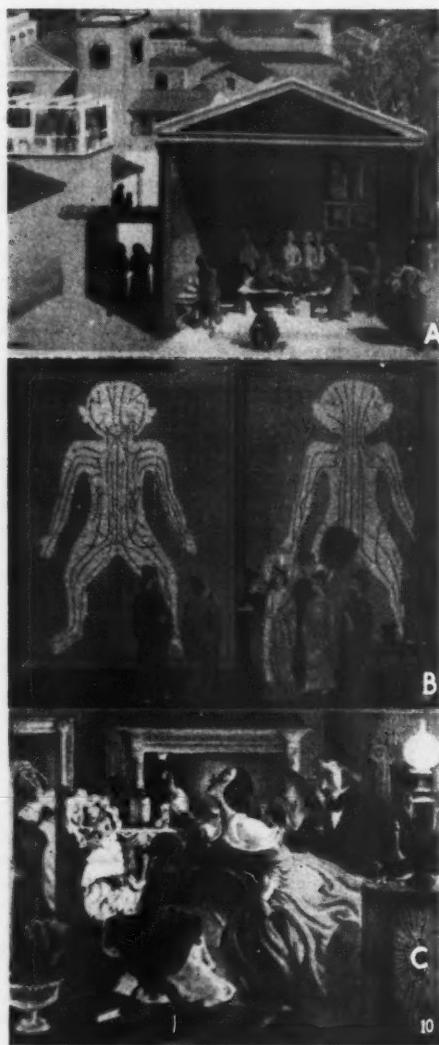


Fig. 10 A. Galen, the Father of Pharmacy.

B: Physicians of the Far East. The Chinese practised medicine in very early times. Possibly the first exponent was the Emperor, Sheng-Non, who lived about 3000 B.C. He compiled the first Chinese *Materia Medica*, by conducting experiments on himself. In 2650 B.C. the Emperor Twang Ti wrote 'All the blood in the body is under the control of the heart... the blood current flows continuously in a circle and never stops.'

C: Port-wine and bark.

GREEK MEDICINE

The first proctoscope, *circa* 300–400 B.C., appears on record in Hippocrates' writing *On Fistulae*, in which he speaks of examining the ulcerated parts of the rectum with a speculum.

Fig. 2 H illustrates an Ephebos, who is an Athenian youth of 18, ready to be called up for military service. He corresponds to our present day undergraduate. These Epheboi were subject to specific ailments due to their age and stresses of life, because of their military training. The present day name for this subject is *Ephebiatrics*.

Fig. 7 F illustrates a newly delivered mother making an offering to Eileithyia, the Greek goddess of childbirth.

The teachings of Galen dominated medicine for over a thousand years. He was a follower of Hippocrates and Aristotle, and conducted some of the earliest physiological experiments on animals (Fig. 10 A). Pharmaceuticals are referred to as galenicals to this very day; and modern chemotherapeutic agents and other drugs are largely the result of the same sort of physiological experiments that were conducted 1,700 years ago by Galen of Pergamos.

ANCIENT CHINA

Fig. 10 B illustrates the ancient physicians of China and the Far East.

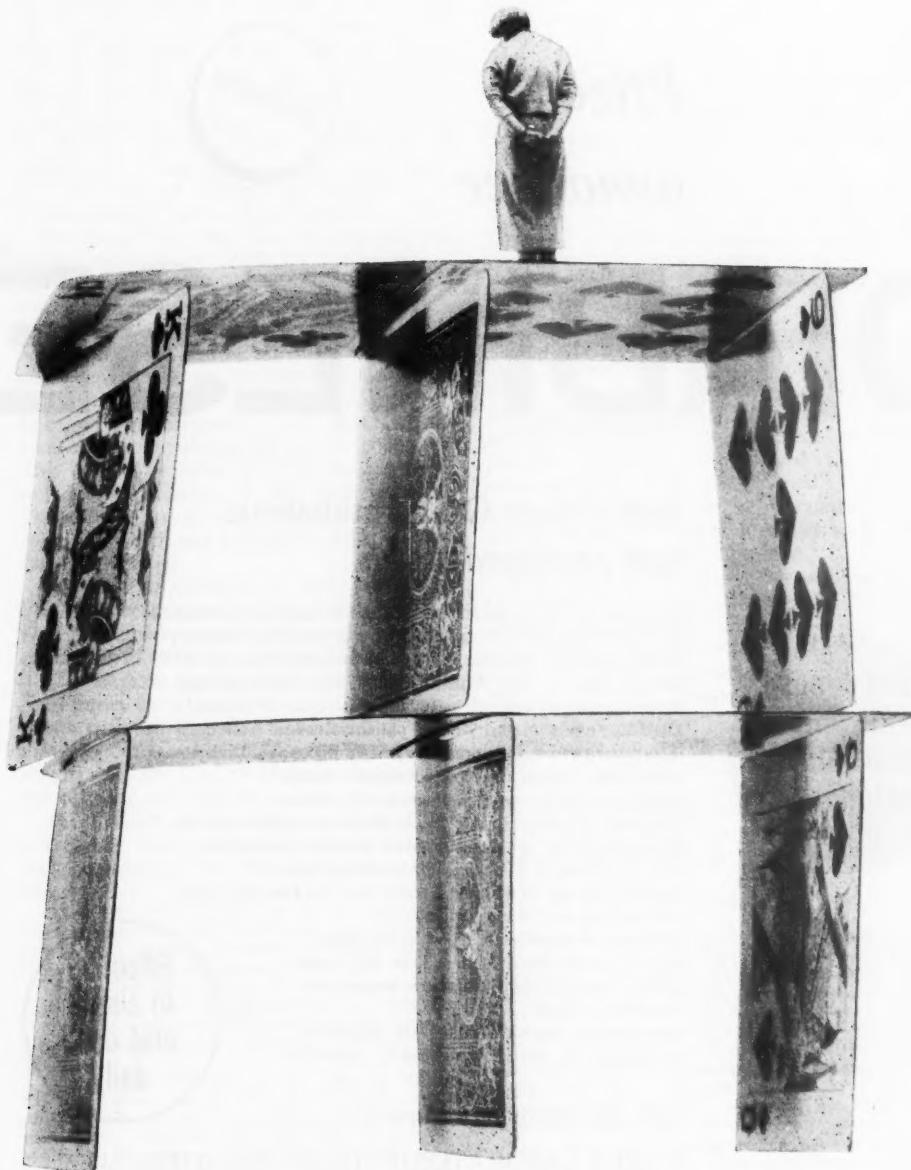
The Temple of Medicine is situated in Wu-shan, Hangchow, and is a magnificent edifice. The exact date of its origin is unknown but, from inscriptions on votive tablets therein, it appears to have been repaired several hundred years ago, in the reign of the Emperor K'ang-Hsi, of the T'sing dynasty.

In the hall, 3 shrines, hewn out of stone and covered with elaborate carvings, hold the 3 deities. Emperor Sheng-Non is seated in the middle, the Doctor of the Celestial Empire occupies the left shrine and the God of Medicine the right shrine.

The Doctor of the Celestial Empire and the God of Medicine are represented as kings, each holding a sceptre in both hands and wearing a tasseled crown decorated with strings of pearls, and a sacrificial robe. One of these two is called Fu-Hsi (Fig. 8 B).

Sheng-Non is represented by an ancient figure with wrinkled brows and carrying two horn-like projections on his head. He is naked, except for a pattern of leaves running over his body (Fig. 7 K).

Twelve smaller altars range to the right and 12 to the left of these main images. They



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are presided over by 24 officials of the Celestial Hospital, which are lesser deities, consisting of the Doctors of the Celestial Empire and the Officials of Medicine. Each of these officials controls a special festival and is responsible for the healing of a certain number of diseases. These healing functions are inscribed on a large tablet before each image and the name of the festival is engraved on a stone incense burner placed before the tablet.

Of Sheng-Non, who was an Emperor and a keen agriculturist, 3000 B.C., it is said in the book *Pien-Chuan* that he was able to distinguish the healing properties of any plant by chewing and swallowing it. The same book states that he had tasted as many as 70 poisonous shrubs in one day and discovered also the remedy for each. Peng-T'sao, the Chinese Pharmacopoeia, was first written according to knowledge gained by Sheng-Non. This book, *The Bible of Sheng-Non*, as some call it, has therefore a very ancient origin. These things are all told in the book *Chu-chechia-yien*, which was painted in the Chow and Chiang dynasties.

The God of Medicine is really a Buddha, *She-Lai*, whose name is *The Great Medicine God*, so called because he delivered the people of the world with his 'Golden Pill.'

The Siamese God of Medicine was always represented in a crouched position, his garments partially slipped off and holding a pill in one outstretched hand. It is not known why, in this case, the God of Medicine is represented formally and holding a pill.

The Officials of the Hospital of the Celestial Empire have control over various diseases, each according to his own speciality, as listed below:

Official Wei Neng Chien of the Hospital of the Celestial Empire controls the cases of phthisis, nocturnal fever, osteitis, weakness of limbs, debility. (Festival: *Li-chun*, 'Beginning of Spring').

Official Wei-Yung Nyuan of the Hospital of the Celestial Empire controls the cases of excitation, nervousness, cardiasthenia, phlegmasia, syphilis, venereal ulcers, abscess in bone. (Festival: *Yu-shui*, 'Rain Water').

Official Miao Wei Ho of the Hospital of the Celestial Empire controls the cases of malaria, dysentery, chronic and acute convulsion, colic, abdominal pain, fever. (Festival: *Koh Yu*, 'Corn Rain').

Official Tu-chia-tseu of the Hospital of the Celestial Empire controls the cases of erysipelas, lumbago, pains in legs and thighs, variola. (Festival: *Li-sba*, 'Beginning of Summer').

Official Ming Ling Faung of the Hospital of the Celestial Empire controls the cases of cough, cough with expectoration, asthma with expectoration, collapse due to expectoration, feverishness and flush due to expectoration, emaciation, asthenia. (Festival: *Ta Shu*, 'Great Heat').

Official Wei Zing Tsung of the Hospital of the Celestial Empire controls the cases of dropsy, oedema,

gas-oedema, splenomegaly, cardialgia, abdominal pain. (Festival: *Li-Chiu*, 'Beginning of Autumn').

Official Tsing Tung Chang of the Hospital of the Celestial Empire controls the cases of boils, furuncles, tinea, scabies, phlegmon, vitiligo, ulcer capitis, swelling, putrefaction. (Festival: *Pei-Lu*, 'White Dew').

Harvey's discovery of the circulation of the blood was preceded by the Emperor Hwang Ti, 2650 B.C., who wrote:

'All the blood in the body is under the control of the heart . . . the blood current flows continually in a circle and never stops.' His book, *Nei Ching* (The Book of Medicine) is, regarding medicine, the foundation of all ancient Chinese literature.

DISCUSSION

Medicine as practised throughout the ages until the 19th century was magico-empirical. The belief was that all disease was caused by humours and by divine intervention. It involved charlatanism, in the form of magic potions, sometimes administered in special drinking cups with their so-called special medicinal qualities. A lot of reliance was placed on nature cure, amulets, talismans, the evil eye, bleedings and cuppings.

The status of the doctor varied from that of a bizarre and a comic character of the 18th century opera in Europe to that of a god, such as Imhotep, who was the physician to King Zoser of the first pyramid fame of Ancient Egypt,* and the Emperors Sheng-Non and Fu-Hsi of ancient China.

SUMMARY AND CONCLUSION

The author reviews the status of medicine and of the doctor in various epochs in different countries throughout the ages.

OPSOMMING

Tot die begin van die 19de eeu was die geneeskunde soos dit deur al die eue heen beoefen is, toweragtig-empiries in sy strekking. Daar is vas geglo dat alle siektes deur liggaamsvloeiwitte en deur goddelike intervensie veroorsaak is. Kwaksalwery was aan die orde van die dag—in die vorm van towerfrankies wat die pasiënt soms moes drink uit spesiale bekers wat dan kwansuis spesiale, geneeskundige eienskappe besit het. Heelwat vertroue is gestel in natuurgeneesings, amulette, talismans, die Bose-oog, en bloedlatinges met koppies of op ander maniere.

Die status van die dokter het gewissel van 'n bizar en komiese karakter uit 'n 18de eeuse Europese opera tot dié van 'n god, soos Imhotep, die geneesheer van koning Zoser wat die eerste piramide in ou Egipte gebou het, en die dokters van keisers Sjeng-Non en Fu-Hsi in die China van ouds.

Die skrywer verstrek 'n oorskig van die status van die geneeskunde en van die dokter in verskillende tydperke in verskillende lande deur al die eue heen.

* A Study of the Antiquities in Relation to Medicine, Surgery and Gynaecology, Med. Proc., 4, 198.

TREATMENT OF FRACTURES OF THE EXTREMITIES*

LIEUTENANT-COLONEL R. E. WATERSON

It is essential that we have a plan for the management of the less severely injured, as well as for the serious cases. I am putting forward a scheme for dealing with some of the fractures—fractures of the upper limb, and of the lower limb below the knee. These are cases which would normally be treated in the out-patient departments of our hospitals. What we want is a standardized scheme of treatment which fulfils the following three criteria:

1. That there is the least possible demand on doctors;
2. That the patient can return home or to a welfare centre and not be dependent upon a hospital bed;
3. That it is safe and requires a minimum of attention for 4-5 days, when the patient can have his final definitive treatment.

It will be universally agreed that for fractures some form of splintage will be necessary, but standard first-aid methods vary enormously and largely depend on improvised splints and most of them do not fulfil the criteria we demand. Our Director-General, Lieutenant-General Sir Alexander Drummond, suggested

* A contribution to a discussion on *The Management of Mass Casualty Situations in Time of War* held under the auspices of the Royal Society of Medicine (United Services Section) on 6 June 1957.

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the use of plaster of Paris for this purpose, and working on this idea a standardized technique of 6 basic 'P.O.P. splints' has been worked out.

At the 'filter unit' cases requiring this treatment are selected by the responsible doctor examining the cases, each is labelled according to his injury and the case passed to the team of orderlies who apply the plaster.

The basis of this whole method of treatment is the use of plaster of Paris in the form of *slabs* or *gutters*—these are applied in the long axis of the limb and are fixed by an open-wove cotton bandage, which is cut when the plaster has set. An essential feature is that in no instance is a limb actually encircled by plaster.

The chief advantage of plaster over other splints is, of course, that it moulds to the contour of the body, and can therefore be applied directly to the body surface without risk of pressure. There is no reason why a slab should not be applied over a silk stocking, a shirt sleeve or a sock, but not over a trouser leg or a jacket sleeve and not over a shoe.

The splints shown in Fig. 1 are, of course, intended for the treatment of simple fractures, but the method is also applicable to the treatment of compound fractures with the proviso that the patient would have to remain under close medical care. Also, and most important, the slab would have to be applied over a dress-

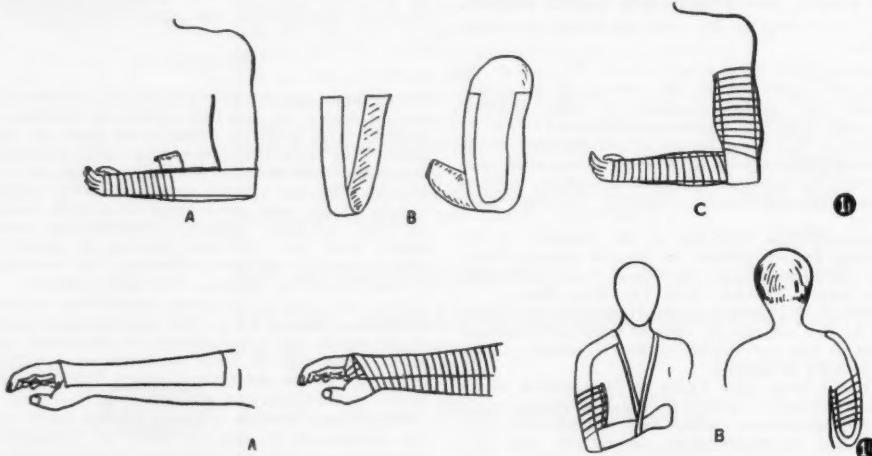


Fig. 1 (i). Full arm splint.
B: U slab (lateral view).

Fig. 1 (ii). Humerus splint.
A: Forearm splint. B: Lower third.



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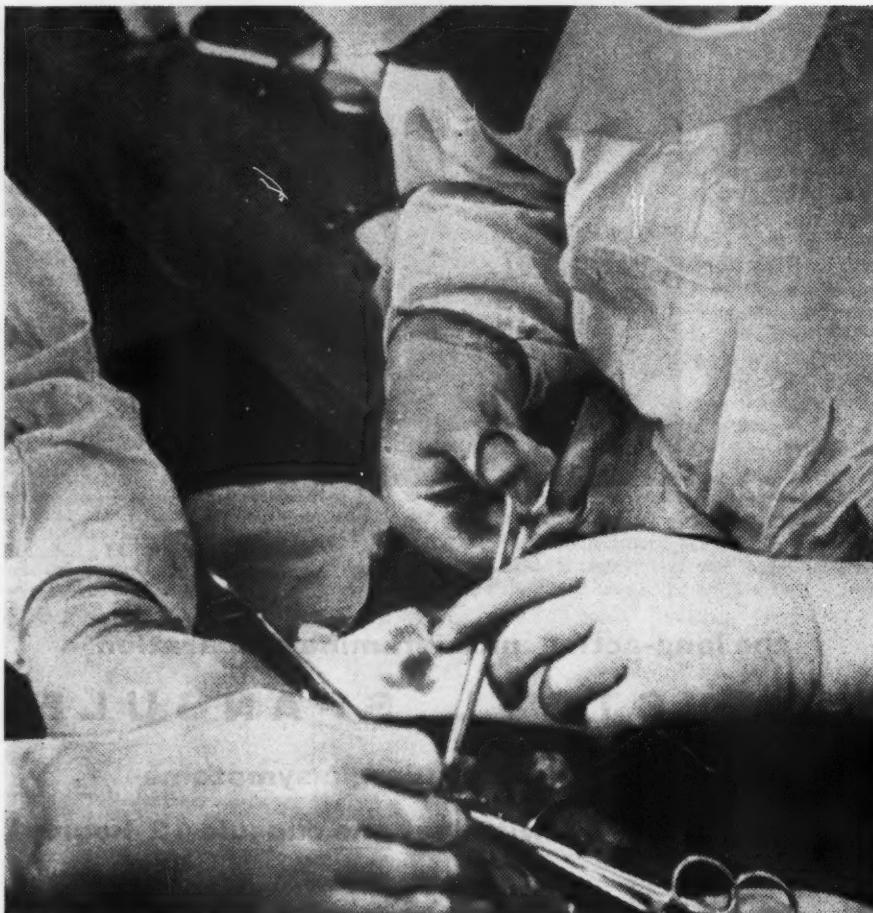
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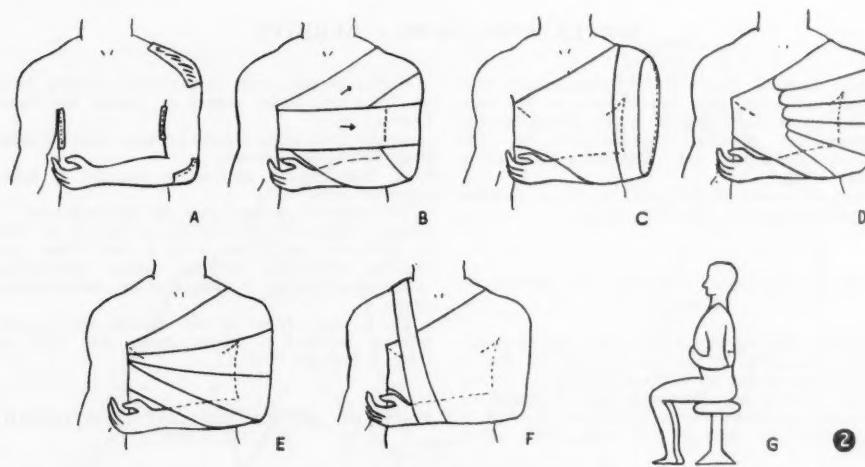


Fig. 2. Thoraco-brachial splint.

A: Padding.
D: Third bandage.

B: First bandage.
E: Fifth bandage.

C: Second and fourth bandage.
F: Sixth bandage.

ing and when the plaster had set the cotton bandage would be cut all the way up. Our orderlies who are taught to apply these plasters work in teams of two, one to apply the plaster assisted by the second who supports the limb. They are taught to instruct patients to elevate the limb afterwards to avoid reactionary swelling.

The next 'P.O.P.' is the thoraco-brachial plaster (Fig. 2). This splint is included in the series because in the last war it proved to be such an invaluable splint for evacuating cases of shoulder injury and fractures of the upper end of the humerus. It is applied with 4 pads to protect pressure points and though it encircles the chest the arm is not encircled.

Lower Limb P.O.P.'s. Fig. 3 demonstrates:

1. Below-knee plaster for fractures in ankle region.

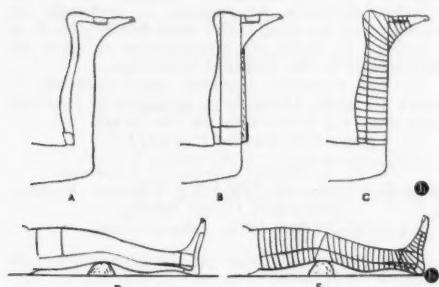


Fig. 3 (i). Below knee splint.

Fig. 3 (ii). Long leg splint.

The method for the below-knee P.O.P. is to apply this with the patient prone. With 2-men teams this is the simplest method for applying plaster, though not of course for maintaining the reduction of the fracture. I should explain that in all these cases we do not expect orderlies to reduce the displacement, though they are expected to correct any angular deformity. The patient's final treatment takes place 4-5 days later under medical care.

2. *Long-Limb P.O.P.* This plaster is intended for fractures of the shaft of the tibia. With some support behind the knee, 2 long antero-medial and antero-lateral slabs are applied from mid-thigh to foot. These are fixed with an open-wove bandage. The foot is steadied by one orderly while the second does the plastering.

These methods are applicable to patients being treated at the filter unit, but it may well happen that a patient admitted to hospital with another injury may also have a fracture, in which case a plaster splint could be made in the hospital ward. This is the reason why I include a chest plaster—a simple plaster encircling the thorax—which has been devised in consultation with thoracic surgeons for bilateral rib fractures or floating sternums in which there is paradoxical movement of the chest wall. I am assured that this plaster does help to fix the chest wall and enable the patient to use his diaphragm to the best advantage.

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THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

At the last meeting of the Council, a Special Disciplinary Committee of the Council reported that it had held an enquiry in terms of Section 81 of the Medical, Dental and Pharmacy Act, in regard to the matters mentioned therein, relating to Dr. J. F. S. The enquiry was held on 2 October 1958, as to whether:

1. He had become unfit to purchase, acquire, keep, use, prescribe, order, supply or possess any habit-forming drug;
2. He had been using a habit-forming drug for other than medicinal purposes;
3. He had become addicted to the use of habit-forming drugs.

After hearing evidence the Committee considered its finding and made certain recommendations to the Council. The Council considered these recommendations at its meeting held in Pretoria on 5 January 1959, and it found that Dr. J. F. S.:

- i. Has become unfit to purchase, acquire, keep, use, prescribe, order, supply or possess any habit-forming drug;
- ii. Has been using a habit-forming drug for other than medicinal purposes;
- iii. Has become addicted to the use of habit-forming drugs.

The Council resolved that he be prohibited in terms of Section 81 (2) (b) (ii) of Act 13 of 1928, as amended, for a period of 1 year, from purchasing, acquiring, keeping, using, prescribing, ordering, supplying or possessing any habit-forming drug.

Dr. S. was advised of this decision and the prohibition referred to above comes into effect as from 9 January 1959.

At the last meeting of the Council, a Special Disciplinary Committee of the Council reported that it had held an enquiry in terms of Section 81 of the Medical, Dental and Pharmacy Act, in regard to the matters mentioned therein, relating to Dr. F. J. K. The enquiry was held on 6 November 1958, as to whether:

1. He had become unfit to purchase, acquire, keep, use, prescribe, order, supply or possess any habit-forming drug;
2. He had been using a habit-forming drug for other than medicinal purposes;
3. He had become addicted to the use of habit-forming drugs.

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Dr. K. was advised of this decision and the prohibition referred to above comes into effect as from 9 January 1959.

* * *

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4. Other things being equal, preference will be given to candidates under 40 years of age.

5. Any medical practitioner registered in South Africa will be eligible for this award.

6. There will be no discrimination for the award on grounds of race, colour, creed or sex.

7. The candidate must submit evidence of his capacity to do original research work.

8. The candidate must submit a programme of the proposed research. He is advised to submit an alternative scheme in case of difficulties about the first one.

9. It is advisable for the candidate to indicate at what institution he proposes to undertake the research and he should also state whether he is in a position to make any arrangements to carry out the research at the proposed institution.

10. The successful candidate must undertake to return to South Africa for a period of at least two years after the termination of the award.

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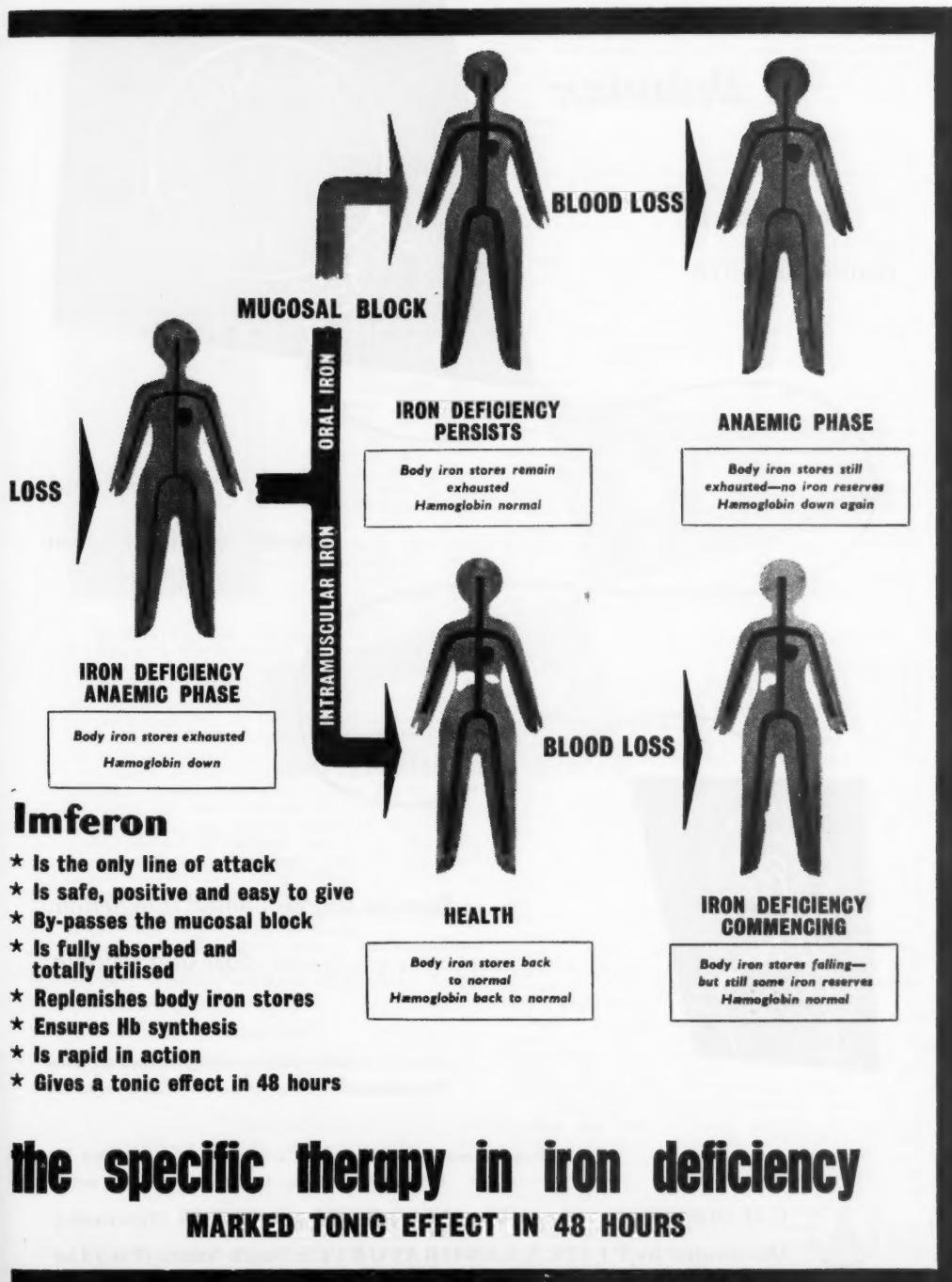
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PREPARATE EN TOESTELLE

CARBOCAINE

Westdene Products (Pty) Ltd. kondig die beskikbaarstelling aan van *Carbocaine*, 'n nuwe plaaslike verdowingsmiddel wat na 12 jaar van intensiewe navorsing deur Bofors, van Swede, geproduseer is.

Dat *Carbocaine* 'n belangrike vordering op die gebied van plaaslike verdowingsmiddels is, word aangetoon deur die veel-eisende farmakologiese en kliniese toets waar-aan dit dwarsdeur die wêreld onderwerp is.

Carbocaine het die volgende onderskeidende kenmerke:

- Vinnige effeksaansvang;
- Opvallende diepte van anestesie;
- Langdurige effek;
- Hoë anestetiese frekwensie;
- Treffende doelmatigheid, selfs sonder 'n vatvernuouer;
- Lae toksisiteit en derhalwe ook 'n lae neue-effekfrekwensie;
- Hoë mate van verenigbaarheid met die weefsels;
- Geen sensitisasie teen adrenaliën nie.



Die werk wat deur Hensel in Duitsland en deur Nordquist in Swede gedoen is, het aangetoon dat *Carbocaine*, anders as ander plaaslike verdowingsmiddels, 'n geringe vatvernuouende effek het. In baie gevalle kan dit derhalwe gebruik word sonder die byvoeging van 'n vatvernuouingsmiddel. Met ander woorde, die neue-effekte wat op die toediening van adrenaliën kan volg, word uitgeskakel.

'n Aantal verslae het reeds in mediese tydskrifte verskyn. Dhunér, bv., skryf:¹ Aan die hand van die toets wat met *Carbocaine* in 1,501 procedures gedoen is, kan daar verklaar word dat dit 'n voor-trefflike middel vir plaaslike narkose is. Die effek daarvan is buitengewoon goed, wat infiltrasie sowel as sper-narkose betref—selfs wanneer adrenaliën nie by die oplossing gevoeg word nie.'

Die waarde van *Carbocaine* in die tandheelkunde is ook deur Gray² en andere beaam.

Nadere besonderhede in verband met *Carbocaine* kan verkry word van die alleenverspreiders vir Suid-Afrika: Westdene Products (Pty) Ltd., Posbus 7710, Johannesburg.

VERWYSINGS

1. Acta Chirurg. Scand., 112, 1956, bl. 350-358.
2. Brit. J. Anaesth., 1957, 29, 210.

DIPASIC

(ISONIKOTIENSUUR-HIDRASIED-P-AMINOSALISILAAT)

VIR ALLE SOORTE TUBERKULOSE

Dipasic werk op 'n manier soortgelyk aan die voor-malige INH/PAS-wisselterapie, maar besit daar-newens verskillende ander voordele vir soer dit ver-draagsaamheid en maklike toediening betref. In

vitro-proefnemings het aangetoon dat *Dipasic* vol-kome doeltreffend is nie alleen teen gevoelige soorte nie, maar ook teen die soorte wat weerstand teen PAS/INH en streptomisin *in vitro* opgebou het. Kliniese toetses het hierdie bakteriologiese resultate bevestig.

Indikasies: *Dipasic* kan vir alle soorte tuberkulose gebruik word. Bevredigende resultate is in gevalle van pulmonale en buite-pulmonale tuberkulose behaal. Kinders, veral, reageer goed op *Dipasic*-terapie, en dis nie langer nodig om hulle streptomisinpuittings te gee nie.

Dosis: Die dosis is afhanglik van die kliniese toestand, maar oor die algemeen word die volgende dosisse aanbeveel:

Vir Volwassenes: 1-2 tablette (d.w.s. 100-200 mg.) per 10 kg. liggaamsgewig per dag.

Vir Kinders: 2-3 tablette (d.w.s. 200-300 mg.) per 10 kg. liggaamsgewig per dag.

Hierdie hoeveelhede word gedurende die dag in die vorm van 3-4 dosisse toegedien.

Dis natuurlik nie moontlik om die duur van die behandeling volgens 'n vasgestelde plan in te kort nie, aangesien iedere pasiënt ooreenkomsdig sy individuele vereistes behandel moet word.

Aanbieding: *Dipasic* word beskikbaar gestel in: Houers van 100 tablette, elk bevattende 100 mg. Houers van 500 tablette, elk bevattende 100 mg. Houers van 1,000 tablette, elk bevattende 100 mg. Houers van 5,000 tablette, elk bevattende 100 mg.

Alleenverspreiders vir Suid-Afrika:

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K-GAR: 'N NUWE NAWELSTRINGKLEMANT

'n Belangrike kenmerk is dat die grootte van die sluitstoel nie vooraf vasgestel word nie. Nadat die nawelstring met die klemant vasgevat is, kan groter druk uitgeoefen word deur die boog in die klemant effens te vergroot. Die totale lengte is 1½ duim, en die breedte van die klemant is 5/16de duim.

Die ligtheid van die materiaal bied ook 'n verdere besliste voordeel. Die gemaklikheid waarmee dit gebruik word en die stewige konstruksie maak dit 'n baie bevredigende instrument.

Nadat die nawelstring is dat die nawelstring geen abnormaliteite vertoon nie, word die klemant aangeleé, en die deel van die nawelstring wat distaal geleé is vir soer dit die klemant betrek, word weggemelk' oor 'n afstand van ongeveer 'n duim waar 'n pinset dan aangebring word. Die string word dan geknip. Op hierdie manier is daar geen gespat van die nawelstringbloed wat dikwels onder groot druk verkeer nie.

Nadat 'n ontsmettingsmiddel aan die oop end gewend is, word 'n stukkie gaas met 'n gaatjie in die middel daarvan oor die klemant geskuif, en 'n verdere vierkantige stukkie gaas word op die gebruiklike manier oor die klemant geplaas.

'n Nuwe *Kateterklemant* waarvan 'n mens maklik ontslae kan raak, en, wat ontwerp en materiaal betref, soortgelyk is aan die nawelstringklemklamp wat hierbo beskryf is, word ook in hierdie land beskikbaar gestel. Hierdie klemant verseker dat geen lekkasie plaasvind nie. Dit is lig, sal nie glip nie, en kan vinnig aangeleé en verwijder word.

Die prys is baie redelik en voorrade is verkrygbaar van Gurr Surgical Instruments (Pty) Ltd., Harleykamers, Kruisstraat 72, Johannesburg.

PREPARATIONS AND APPLIANCES

CARBOCaine

Westdene Products (Pty) Ltd. announce the introduction of *Carbocaine*, a new local anaesthetic produced by Bofors of Sweden following 12 years of intensive research.

Carbocaine represents a considerable development in the field of local anaesthetics as has been shown by exacting pharmacological and clinical investigations throughout the world.

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- Low toxicity and thereby a low side effect frequency;
- High compatibility with tissue;
- No sensitization against adrenaline.

Carbocaine, unlike

other local anaesthetics, has a slight vasoconstricting effect as has been confirmed by the work of Hensel in Germany and Nordquist in Sweden. In many cases therefore it may be used without the addition of a vasoconstrictor, thus avoiding the side effects which can occur following the administration of adrenaline.

A number of reports has already appeared in medical journals; Dhunér, e.g. writes¹:

'From testing *Carbocaine* in 1,501 procedures, it can be stated that it is an excellent drug for local anaesthesia. The action is extremely good both in infiltration and block anaesthesia even if adrenaline is not added to the solution.'

The value of *Carbocaine* has also been confirmed in dentistry by Gray² and others.

Further details regarding *Carbocaine* may be obtained from the sole South African distributors: Westdene Products (Pty) Ltd., P.O. Box 7710, Johannesburg.

REFERENCES

1. Acta Chirurg. Scand., **112**, 1956, pp. 350-358.
2. Brit. J. Anaesth., 1957, **29**, 210.

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Indications: *Dipasic* can be used for all forms of tuberculosis. Satisfactory results have been obtained in pulmonary and extra-pulmonary tuberculosis. Children in particular respond well to *Dipasic* therapy and the need for streptomycin injections is eliminated.

Dosage: The dose level is dependent on the clinical condition but, in general, the following dose levels are recommended:

For Adults: 1-2 tablets (i.e. 100-200 mg.) per 10 Kg. body weight daily.

For Children: 2-3 tablets (i.e. 200-300 mg.) per 10 Kg. body weight daily.

These dose levels are spread over the day in 3-4 doses.

It is, of course, not possible to reduce the duration of treatment to a scheme as each patient must be treated according to individual requirements.

Presentation: *Dipasic* is available in:

Containers of 100 tablets each containing 100 mg.

Containers of 500 tablets each containing 100 mg.

Containers of 1,000 tablets each containing 100 mg.

Containers of 5,000 tablets each containing 100 mg.

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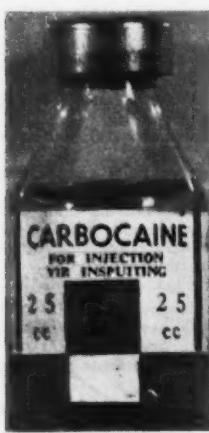
After ascertaining the absence of any abnormality of the cord, the clamp is applied and the cord distal to the clamp is 'milked' away for about an inch where forceps are applied. The cord is then cut. This way there is no spattering of the cord blood, which so often is under considerable pressure.

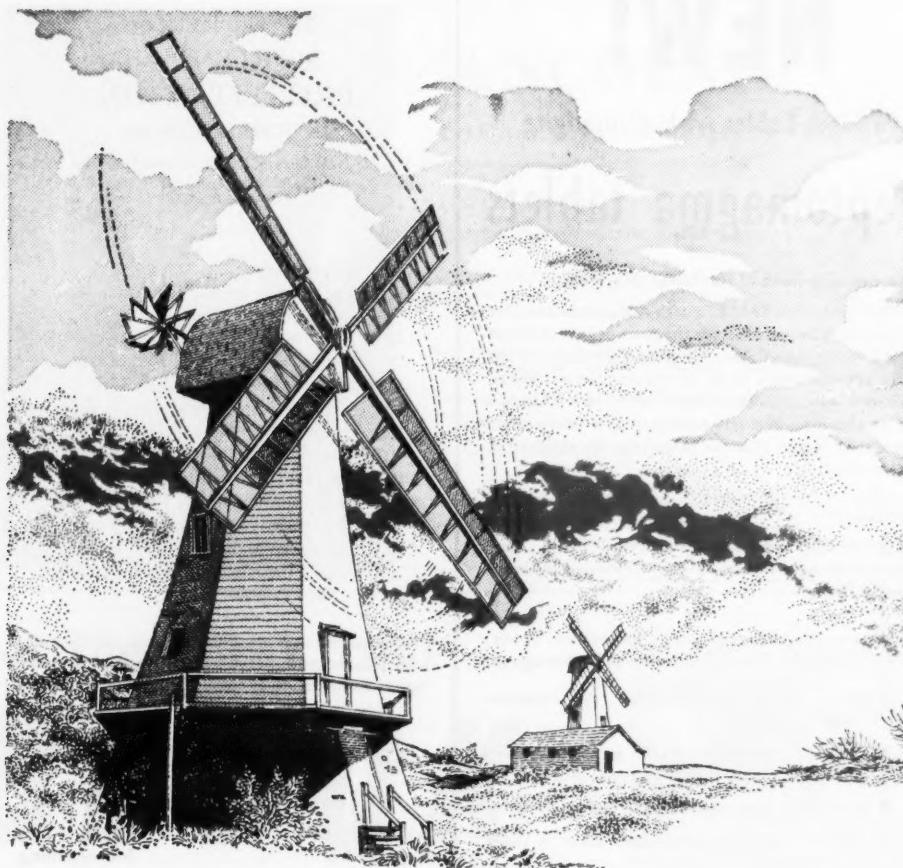
After applying an antiseptic to the open end, a piece of gauze with a hole in the centre is slipped over the clamp and another square piece of gauze put over the clamp in the conventional manner.

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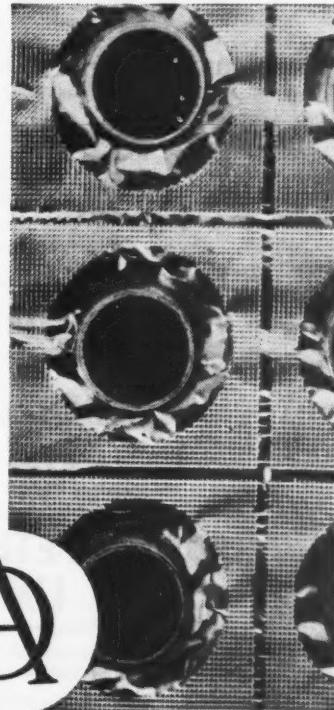
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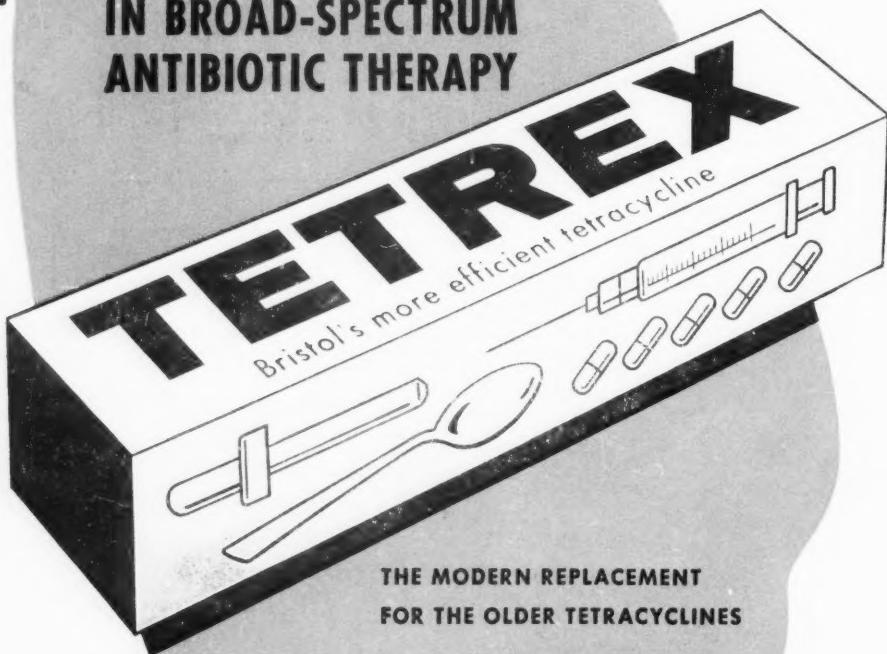
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